In The

Supreme Court of the United States

PHYLLIS J. WOGAN, INDIVIDUALLY AND AS PERSONAL REPRESENTATIVE OF THE ESTATE OF JAMES JOHN WOGAN,

Petitioner,

v.

KENNETH C. KUNZE, M.D. and HILTON HEAD GASTROENTEROLOGY, P.A.,

Respondents.

On Petition For A Writ Of Certiorari To The South Carolina Supreme Court

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Brief Introductory Statement

A Medicare beneficiary brought state law claims of negligence and breach of fiduciary duty against a private physician claiming, in part, that the physician breached the standard of care by refusing to submit Medicare claims, for Medicare covered injections the physician prescribed and administered to the beneficiary. Medicare regulations *required* the Respondents to submit claims for the beneficiary and *prohibited* the beneficiary from submitting his own claims to Medicare for the cost of the medication. The beneficiary was forced to purchase the medication at the pharmacy, pay out of pocket for it and return to the physician's office to have it injected by the physician. Because the physician refused to submit claims, in violation of Medicare regulations, the beneficiary could not obtain his Medicare benefits and personally incurred substantial medical expenses. The South Carolina Supreme Court affirmed the dismissal of decedent's state law claims based on its interpretation of the preemptive scope of 42 U.S.C. § 405(h).

Questions Presented

(1) Does 42 U.S.C. § 405(h) preempt the Medicare beneficiary's state law claims?

(2) Has the ruling of the South Carolina Supreme Court, which found that § 405(h) preempts the Medicare beneficiary's state law claims, caused the Medicare beneficiary to suffer a denial of Medicare benefits without due process of law by denying access to the courts?

QUESTIONS PRESENTED – Continued

(3) If it is argued that the ruling of the South Carolina Supreme Court is based on independent state law grounds, which is denied, does the ruling of the South Carolina Supreme Court deny the Medicare beneficiary and those similarly situated Medicare beneficiaries equal protection of the law by denying access to the courts?

LIST OF PARTIES

The Petitioner's complaint alleged negligence (*See infra* App. 69) and loss of consortium (*See infra* App. 115) related to an unnecessary abdominal surgery and post operative care. These claims were asserted against the following Defendants and have been stayed pending the outcome of the appellate process:

(a) Kenneth C. Kunze, M.D. and his professional association, Hilton Head Gastroenterology, P.A.;

(b) Gary W. Thomas, M.D. and his professional association, Gary W. Thomas, M.D., P.A.; and

(c) Thomas P. Rzeczycki, M.D. and his professional association, Hilton Head General and Laparoscopic Surgery, P.A.

The Petitioner's complaint also alleged negligence (*See infra* App. 90, ¶ 89(n), (o) and (p)), breach of third party beneficiary contract (*See infra* App. 108), breach of fiduciary duty (*See infra* App. 112) and unfair trade practices (*See infra* App. 111) against:

(a) Kenneth C. Kunz, M.D. and his professional association; and

(b) Gary W. Thomas, M.D. and his professional association

These state law claims were based on the refusal of these Defendants to file claims to Medicare in

LIST OF PARTIES – Continued

violation of Medicare regulations due, in part, to their own financial self interest. These are the state law claims that were dismissed on summary judgment and were appealed to the South Carolina Court of Appeals.

However, the only claims appealed to the South Carolina Supreme Court were Petitioner's claims of negligence and breach of fiduciary duty against Kenneth C. Kunze, M.D. and his professional association. Therefore, the only Respondents relevant to this petition are Kenneth C. Kunze, M.D. and Hilton Head Gastroenterology, P.A. involving Petitioner's state law claims of negligence and breach of fiduciary duty.

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Petitioner, Phyllis J. Wogan, Individually and as Personal Representative of the Estate of James John Wogan, respectfully petitions for a writ of certiorari to review the decision of the South Carolina Supreme Court in this case, which has vastly and inaccurately expanded the scope of Medicare Act preemption.

OPINIONS BELOW

The decision of the South Carolina Supreme Court (*See infra* App. 1-11) is reported at 379 S.C. 581, 666 S.E.2d 901 (2008). The decision of the South Carolina Court of Appeals (*See infra* App. 12-49) is reported at 366 S.C. 583, 623 S.E.2d 107 (S.C. Ct. App. 2005).

JURISDICTION

The South Carolina Supreme Court denied a rehearing of this case on October 9, 2008. (*See infra* App. 61-62). This Petition for a Writ of Certiorari is timely filed pursuant to *Rule 13* of this Court's rules.

This Honorable Court, in its discretionary authority, has jurisdiction in this matter because:

(a) The South Carolina Supreme Court has inaccurately expanded the scope of Medicare Act preemption to include state law claims brought by a beneficiary against a private physician who, based

on financial self interest, interfered with and ultimately blocked the beneficiary's ability to receive Medicare benefits for Medicare covered injections. This decision, which is tantamount to complete preemption, is in conflict with the decisions of another state court of last resort or a United States court of appeals;

(b) The South Carolina Supreme Court's ruling denies the Decedent the due process rights explained in *Grijalva v. Shalala*, 152 F.3d 1115 (9th Cir. 1998) and protected by the Fifth and Fourteenth Amendments of the United States Constitution by denying him and others similarly situated access to the courts; and

(c) The South Carolina Supreme Court ruling, if based on independent state law grounds, which is denied, denies the Decedent and those similarly situated South Carolina Medicare beneficiaries equal protection of the law guaranteed by the Fourteenth Amendment of the United States Constitution by denying them access to the courts.

STATUTES INVOLVED

Section 205(h) of Title II of the Social Security Act, 42 U.S.C. § 405(h), made applicable to the Medicare Act by 42 U.S.C. § 1395ii, provides:

"The findings and decisions of the [Secretary of Health and Human Services] after a hearing

> shall be binding upon all individuals who are parties to such hearing. No Findings of fact or decisions of the [Secretary of Health and Human Services] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [Secretary of Health and Human Services], or any officer or employee thereof shall be brought under section 1331 or 1345 of title 28, U.S. Code, to recover on any claim arising under this title."

This matter involves the application and scope of 42 U.S.C. § 405(h) and, more importantly, whether 42 U.S.C. § 405(h) preempts state law claims brought by a Medicare beneficiary against a private physician who, based on financial self interest, interfered with and ultimately blocked the beneficiary's ability to receive Medicare benefits for Medicare covered injections.

STATEMENT OF THE CASE

A. Factual Background

The Decedent was a Medicare Part B beneficiary suffering from a terminal illness. (*See infra* App. 80, ¶ 42 and App. 109, ¶ 93-94). He was under the care and treatment of the Respondent, Kenneth C. Kunze, M.D., a private Medicare participating physician. (*See infra* App. 80, ¶ 42 – App. 83, ¶ 55; and App. 108, ¶ 92 – App. 109, ¶ 94). During the time the beneficiary was being treated by the Respondent, the Respondent initiated

and prescribed a medication to alleviate the Decedent's life threatening diarrhea. (*See infra* App. 84, ¶ 62-64). The monthly injections were required to be given by and under the supervision of the Respondent. (*See infra* App. 84, ¶ 64). If the Decedent did not receive his monthly injection he would lapse into an immediate medical crisis and end up in a hospital emergency room.

During a post operative office examination, the Respondent informed the beneficiary that the medication was covered by Medicare and that he would give the injections in his office each month. (*See infra* App. 84, ¶ 62-63). The fact that the medication at issue is covered by Medicare is also supported by the uncontradicted expert testimony in the record. (*See infra* App. 136, ¶ 17(c)(d) and App. 157, ¶ 19). During this post operative office examination the Respondent also informed the Decedent that he would submit claims each month from his office to Medicare for the medication that was being administered. (*See infra* App. 84, ¶ 63).

While it will be discussed in more detail later in this petition it should be noted immediately that the Respondent was *required* by Medicare regulations to submit claims to Medicare for the beneficiary and the beneficiary was *prohibited* by those same regulations from submitting his own claims to Medicare for the cost of the medication.

Just prior to the first injection in May 2001, the Respondent by and through his office nurse, Geri

Burr, informed the decedent that Respondent did not want to wait to be reimbursed by Medicare for the medication's cost and that he was refusing to submit claims to Medicare. (*See infra* App. 85, ¶ 69 – App. 86, ¶ 75; and App. 122-130). The Respondent forced the beneficiary to purchase the injections each month at a pharmacy and return to his office with the medication where he would inject the beneficiary. (*See infra* App. 85, ¶ 66-App. 86, ¶ 76; and App. 87, ¶ 80). The Decedent's out of pocket cost for the medication was approximately two thousand seven hundred ($2,700.00) dollars per injection. (*See infra* App. 86, ¶ 76). Although the Respondent refused to submit claims to Medicare for the cost of the medication he repeatedly submitted claims to Medicare to be paid for his professional service of injecting the medication each month.

Between May 2001 and September 2001, the beneficiary constantly and repeatedly pled with the Respondent to submit the claims to Medicare for the cost of the medication because he could no longer afford to purchase the medication at the pharmacy each month. The Respondent ignored all requests. (*See infra* App. 87, ¶ 78-80; and App. 88, ¶ 82). The beneficiary died in October 2001. (*See infra* App. 89, ¶ 88). Because the Respondent refused to submit claims, in violation of Medicare regulations, and the beneficiary was prohibited from submitting his own claims, no claims were ever filed with Medicare. By the time of the beneficiary's death, he paid, out of pocket, more than eight thousand ($8,000.00) dollars to obtain the Medicare covered injections at the pharmacy.

B. Proceedings Below

The Estate of the beneficiary brought numerous state law claims against the Respondent, including breach of fiduciary duty and negligence. The Estate sought both economic and non-economic damages. (*See infra* App. 69 and App. 112). As one means of supporting its state law negligence claims, the Estate alleged that the Respondent violated Medicare regulations which required him to submit the claims when requested to do so by the beneficiary. (*See infra* App. 93, ¶ 89(n), (o) and (p)). The Estate supported these claims by uncontradicted expert affidavit testimony which established a breach of professional duty by the Respondent due to his failure to file or assist the Decedent between May 2001 and October 2001. (*See infra* App. 156, ¶ 16(m) and ¶ 18).

The Respondent filed for summary judgment arguing that the Estate was attempting to assert a private right of action under the Medicare Act when one did not exist. The trial court concurred with Respondent's argument and dismissed the claims of the Estate. (*See infra* App. 56, ¶ 1). The Estate appealed to the South Carolina Court of Appeals.

On September 26, 2005, the South Carolina Court of Appeals affirmed the trial court's ruling that the Estate was attempting to assert a private right of action under the Medicare Act where one did not exist. (*See infra* App. 48, "Conclusion"). The Estate

filed a Petition for a Writ of Certiorari with the South Carolina Supreme Court. The writ was granted.

At the South Carolina Supreme Court, and for the first time, the Respondent argued that the Medicare Act preempted the Estate's state law claims. *See Final Brief of Respondent: Argument I* <http://www.judicial.state.sc.us/caseOfMonth/May2008/>.[1] On September 8, 2008, the South Carolina Supreme Court issued its opinion modifying the Court of Appeals' opinion but concurring in the result reached. (*See infra* App. 1-11).

The South Carolina Supreme Court modified the South Carolina Court of Appeals' decision as it related to the private right of action issue. Contrary to the South Carolina Court of Appeals, the South Carolina Supreme Court held that violation of a Medicare statute could conceivably be used to support a state law negligence claim and reliance on such was not an attempt to assert a private right of action under the Medicare Act. (*See infra* App. 10, FN 6). The South Carolina Supreme Court, however, relying on *Heckler v. Ringer* and *Ardary v. Aetna Health Plans*, held that if violation of the Medicare statute being relied upon caused *economic* damages to the Medicare beneficiary, the Medicare Act preempted

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[1] This case was selected as "Case of the Month" by the South Carolina Supreme Court. All briefs and a video of oral arguments can be found at this web address.

those claims.[2] Finding that the Estate's damages were purely economic, the South Carolina Supreme Court was able to affirm the result reached by the South Carolina Court of Appeals.[3] (*See infra* App. 9, ¶ 3-App. 11).

REASONS FOR GRANTING THE PETITION

This Honorable Court, in its discretionary authority, should grant this Petition for a Writ of Certiorari because it involves the following compelling and important issues:

(a) This case involves one or more substantial federal questions which have been erroneously decided by the South Carolina Supreme Court, most importantly the scope of Medicare Act preemption;

(b) The substantial federal questions involved in this case were raised by the parties and ruled upon by the South Carolina Supreme Court;

(c) The South Carolina Supreme Court provided no independent state law grounds to affirm the lower court's dismissal of the state law claims and relied solely on

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[2] *Heckler v. Ringer,* 466 U.S. 602 (1984) and *Ardary v. Aetna Health Plans of California, Inc.*, 98 F.3d 496 (9th Cir. 1996).

[3] The South Carolina Supreme Court implicitly found that the beneficiary suffered no non-economic damages. The Estate requested limited remand for a hearing on the issue of damages; however, this request was denied.

its interpretation of the Medicare Act's preemptive scope;

(d) Unless reviewed and corrected, the erroneous expansion of Medicare Act preemption by the South Carolina Supreme Court will continue to adversely affect a large number of federal Medicare beneficiaries by denying them due process and equal protection; and

(e) While the instant case involves a Medicare beneficiary and a private physician under Medicare Part B, the South Carolina Supreme Court's erroneous expansion of the preemptive scope of the Medicare Act will impact thousands of Medicare beneficiaries under all Medicare parts, including Medicare's Part D prescription coverage.

Petitioner seeks review of the ruling of the South Carolina Supreme Court which holds that the Medicare Act completely preempts a state law claim brought against a private physician who, based on financial self interest, interfered with and ultimately blocked the beneficiary's ability to receive Medicare benefits for Medicare covered injections. This ruling conflicts with current rulings of the federal courts which hold that the Medicare Act does not preempt these state law claims. This ruling has denied the Decedent and those similarly situated due process. More importantly, the impact of this ruling goes beyond this state and beyond the instant litigants. It is a ruling that substantially limits the remedies available to a Medicare beneficiary for a negligent or

intentional interference and/or blocking of Medicare benefits by a private physician due to that physician's private financial self interest. It is also a ruling that informs physicians who chose to violate Medicare regulations, established by Congress and intended to protect the beneficiary, that they can do so and escape all responsibility as long as violations cause only economic damage to the beneficiary. It is a ruling that will cause a large number of Medicare beneficiaries to suffer crushing medical expenses at the hands of a negligent self interested physician – medical expenses Congress determined should be covered by the Medicare program. More important than the moral hazard involved, these Medicare beneficiaries will be left with no mechanism to remedy or address the clear wrong they have suffered because access to the courts has been blocked.

I. BY RELYING ON THE JURISDICTIONAL PROVISIONS OF 42 U.S.C. § 405(h) AND NOT THE PREEMPTIVE PROVISIONS OF THAT SECTION, THE SOUTH CAROLINA SUPREME COURT HAS IMPROPERLY AND INACCURATELY EXPANDED THE SCOPE OF MEDICARE ACT PREEMPTION.

The South Carolina Supreme Court has improperly expanded the scope of Medicare Act preemption. By analyzing this case under the jurisdictional provisions of 42 U.S.C. § 405(h) and not the preemptive provisions of § 405(h), the South Carolina Supreme

Court vastly expanded the limited nature of Medicare Act preemption to a point of complete preemption. This ruling and the resulting expansion of Medicare Act preemption conflicts with the decisions of another state court of last resort and/or of a United States court of appeals. If the ruling of the South Carolina Supreme Court is not reviewed and corrected, the improper expansion of Medicare Act preemption can, and will, be used as precedent to substantially dilute the rights and protections afforded Medicare beneficiaries by blocking their access to the courts.

It should be noted at the outset of this Petition, and as discussed in more detail below, although a complete analysis of 42 U.S.C. § 405(h) is lacking in the South Carolina Supreme Court's opinion there can be no doubt that its decision is based entirely on § 405(h) and, more particularly, the "arising under" term found in the last sentence of § 405(h).

First, the South Carolina Supreme Court relied almost entirely on *Heckler v. Ringer,* 466 U.S. 602 (1984) and *Ardary v. Aetna Health Plans of California, Inc.*, 98 F.3d 496 (9th Cir. 1996) in its opinion. Both *Ringer* and *Ardary* address the limitation of federal court jurisdiction as set forth in § 405(h). Additionally, as seen below, the words chosen by the South Carolina Supreme Court, in its written opinion, leave no doubt its reasoning in affirming the dismissal of Decedent's claims is based on *Ringer*, *Ardary* and the jurisdictional term "arising under" found in the last sentence of § 405(h), discussed in those cases. Accordingly, it is clear that the South

Carolina Supreme Court decided the instant case based on the federal court jurisdictional limits set forth in § 405(h).

42 U.S.C. § 405(h) contains only three sentences. The first two sentences of § 405(h) state:

> The findings and decisions of the [Secretary of Health and Human Services] after a hearing shall be binding upon all individuals who are parties to such hearing. No findings of fact or decision of the [Secretary of Health and Human Services] shall be reviewed by any person, tribunal, or governmental agency except as herein provided.

These two sentences constitute Medicare's preemptive scope and limit the ability of "any person, tribunal, or governmental agency" to review the "findings of fact and decisions of the Secretary" as they relate to Medicare coverage. Additionally, it is clear that any claims which seek to challenge the "findings of fact and decisions of the Secretary" must be reviewed through Medicare's administrative process. *See* 42 U.S.C. § 405(g).

There is absolutely nothing contained in the language of the first two sentences of § 405(h) which would support the preemption of state law negligence and breach of fiduciary duty claims brought by a beneficiary against a private physician. The first two sentences of § 405(h) do not apply to Decedent's claims and provide no support for the dismissal of those claims.

Instead of analyzing the Respondents' preemption arguments under the first two sentences of § 405(h), which comprise the preemptive scope of the Medicare Act, the South Carolina Supreme Court chose to analyze those preemption arguments pursuant to the third sentence of § 405(h). The third sentence of § 405(h) is a provision which limits federal court jurisdiction. The third sentence of § 405(h) limits *certain claims* from being brought in *federal court*. The third sentence of § 405(h) does not preempt state law negligence and breach of fiduciary duty claims brought in state court against a private physician and it does not preempt Decedent's economic claims.

Specifically, the third sentence of § 405(h), states:

> No action against the United States, the [Secretary of Health and Human Services], or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

This third sentence of § 405(h), removes the federal court's ability to hear any claim which (1) is "brought against the United States, the [Secretary] or any officer or employee thereof;" (2) is "brought under section 1331 or 1346 of title 28;" and, most

importantly, (3) seeks "to recover on any claim arising under" the Medicare Act.[4]

Even assuming the South Carolina Supreme Court was correct in analyzing Respondents' preemption argument under the last sentence of § 405(h), the South Carolina Supreme Court should have quickly dismissed that argument because Decedent's state law claims were not brought against the "United States, the [Secretary] or any officer or employee thereof" nor were those claims brought pursuant to 28 U.S.C. § 1331 or 28 U.S.C. § 1346. The South Carolina Supreme Court appears to have completely bypassed the fact that these two elements are lacking in Decedent's case and used what they believed to be the presence of the third element (i.e. a claim "arising under" the Medicare Act) to affirm the dismissal of Decedent's state law causes of action.

As stated above, the South Carolina Supreme Court's analysis of § 405(h) is lacking in its written opinion; however, what is clear is that the court improperly seized upon the "arising under" term

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[4] The first element should be read to include not only claims brought against the "United States, the Secretary, or any officer or employee thereof" but also Medicare carriers such as Aetna. *See Bodimetric Health Services v. Aetna Life & Cas.*, 903 F.2d 480 (C.A. 7 (Ill.) 1990) ("We therefore conclude that suits against fiscal intermediaries are governed by the terms of section 405(h)"). This is why most, if not all, cases involving preemption involve the United States, the Secretary of DHHS or a Medicare carrier, such as Aetna, as a Defendant and not a private physician like the Respondent.

found in the jurisdictional last sentence of § 405(h) to determine whether Decedent's state law claims are preempted by the Medicare Act. The South Carolina Supreme Court, in its discussion of the "arising under" jurisdictional analysis relied almost entirely on *Ringer* and *Ardary*. Both *Ringer* and *Ardary* involved issues of the federal court's limited jurisdiction pursuant to the last sentence of § 405(h). As such, the *Ringer* and *Ardary* Courts were required to define what was meant by the "arising under" terminology found in the jurisdictional last sentence of § 405(h).

In *Ringer*, this Honorable Court held that "to be true to the language of the statute, the inquiry in determining whether § 405(h) **bars federal question jurisdiction** must be whether the claim 'arises under' the act." *Id.* at 615 (emphasis added). The "arising under" inquiry itself turns on whether the Act "provides both the substance and the standing for [the Plaintiffs] claims," *Id.* at 620, or whether the claim is "inextricably intertwined" with a claim for Medicare benefits. *Id.* at 614 and *Ardary* at 500.

Even if the analysis of the issues in this case was appropriate under the jurisdictional last sentence of § 405(h), had the South Carolina Supreme Court engaged in a full analysis of the last sentence of § 405(h) and the third element contained therein, (i.e. the "arising under" jurisdictional term), the court would have first found that the Decedent's claims do not "arise under" the Medicare Act because the Medicare Act does not provide either the substance or the

standing for Decedent's claims. Decedent's claims are based on state tort law. (*See infra* App. 69 and App. 112).

After eliminating both standing and substance, the South Carolina Supreme Court would have then been required to turn to the issue of whether the Decedent's claims were "inextricably intertwined" with a claim for Medicare benefits. Even though inapplicable, the South Carolina Supreme Court undertook this analysis and this analysis comprised most, if not all, of the Court's opinion. Relying on *Ringer* and *Ardary*, the South Carolina Supreme Court found that the Decedent's claims "arose under" the Medicare Act because they were "inextricably intertwined" with the Medicare Act and thus those claims were found to be preempted by the Medicare Act.

Specifically, the South Carolina Supreme Court ruled:

> (a) Although Wogan characterizes her cause of action as a state law claim for negligence, it is, at bottom, a claim for reimbursement of the $2,000 per month which was expended on Sandostatin LAR prior to Mr. Wogan's death. Her claim is therefore **"inextricably intertwined"** with the refusal to file a claim . . . (*See infra* App. 9, ¶ 3 – App. 10) and
>
> (b) Once again, the underlying basis of the breach of fiduciary duty claim is that

> Wogan seeks reimbursement of the expenses she suffered by having to pay for the Sandostatin LAR for three months out-of-pocket. Pursuant to *Heckler* [*v. Ringer*] and *Ardary*, we find Wogan's claim is **at bottom** an attempt to recover monies which would otherwise have been paid by Medicare. (*See infra* App. 10, ¶ 2 – App. 11).

After finding that the Decedent's claims "arose under" the Medicare Act, the South Carolina Supreme Court affirmed the dismissal of Decedent's claims which sought economic damages caused by the Respondents' interference with the Decedent's medicare benefits. This was the sole basis the South Carolina Supreme Court used to affirm the dismissal of Decedent's claims.

First, this Honorable Court made clear in *Ringer* that the "arising under" (i.e. "inextricably intertwined) analysis is only relevant to determine the limitation § 405(h) places on federal court jurisdiction when it stated, "[T]he inquiry in determining whether § 405(h) bars **federal question jurisdiction** must be whether the claim 'arises under' the Medicare Act . . . " *Id.* at 615 (emphasis added).

Once again, this Honorable Court, in *Shalala v. Illinois Council of Longterm Care, Inc.*, 529 U.S. 1 (2000), addressed the "arising under" jurisdictional analysis and, in that case, emphasized not only its jurisdictional nature but also its limited applicability to only those cases where the claimant is seeking

monetary benefit from Medicare by and through a challenge of Medicare's coverage decision. In *Illinois Council*, this court stated:

> The scope of the italicized language "to recover on any claim arising under" the Social Security (or, as incorporated through § 1395ii, the Medicare) Act is, if read alone, uncertain. Those words clearly apply in a typical Social Security or Medicare benefits case, where an individual seeks a monetary benefit from the agency (say, a disability payment, or payment for some medical procedure), the agency denies the benefit, and the individual challenges the lawfulness of that denial. The statute plainly bars § 1331 review in such a case . . .

Id. at 10.

Finally, the impropriety of the South Carolina Supreme Court's reliance on the jurisdictional "arising under" terminology to dismiss the Decedent's state law claims, as preempted, is made clear in *Christus Health Gulf Coast v. Aetna, Inc.*, 237 S.W.3d 338 (Tex. 2007). The *Christus* court stated, "[T]he significance of the 'arising under' analysis set forth in *Heckler* [sic] is relevant only for purposes of **assessing subject matter jurisdiction issues in federal court** when plaintiffs pursue **'action[s] against the United States, the [Secretary of HHS], or any officer or employee thereof.'** *Id.* at 343 (emphasis added).

The South Carolina Supreme Court erred in subjecting the Decedent's claims to the jurisdictional

"arising under" analysis because (1) they do not involve questions of federal jurisdiction; (2) they are not against the United States, the [Secretary] or any officer or employee thereof; and (3) they do not seek monetary benefit from medicare and are not challenging the lawfulness of a denial by medicare.

The Decedent seeks damages from a private physician who, based on financial self interest, interfered with and ultimately blocked the beneficiary's ability to receive Medicare benefits for Medicare covered injections. The uncontradicted evidence in the record shows that this was a breach of the standard of care by that physician. (*See infra* App. 156, ¶ 16(m); and App. 157, ¶ 18).

The erroneous decision of the South Carolina Supreme Court has led to complete preemption of state law claims seeking economic damages; however, "preemption will not lie unless it is the clear and manifest purpose of Congress." *Simmons v. Mark Lift Industries, Inc.*, 622 S.E.2d 213, 224 (S.C. 2005) (citing *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). As well put by the United States District Court for the Northern District of Georgia, in referring to state law claims, "The Court acknowledges that Congress did not intend to preclude residents from pursuing common law remedies. Indeed, both the Medicare and Medicaid statutes specify that the remedies provided 'shall not be construed as limiting such other remedies, including any remedy available to an individual at common law." *Brogdon ex rel.*

Cline v. National Healthcare Corp., 103 F.Supp.2d 1322, 1331 (N.D. Ga. 2000) (citing 42 U.S.C. § 1395i-3(h)(5), § 1396r(h)(8)).

In fact:

> Circuit and Supreme Court precedent counsels caution in finding that a federal statute completely preempts state law claims. We have noted that "the [Supreme] Court has revisited the complete preemption doctrine only sparingly" and has found complete preemption only in the context of two federal statutes – the Labor Management Relations Act (LMRA), 29 U.S.C. § 141, *et seq.*, and the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001, *et seq.* Furthermore, "although the Supreme Court recognizes the existence of the complete preemption doctrine, the Court does so hesitatingly and displays no enthusiasm to extend the doctrine into areas of law beyond the LMRA and ERISA." *Smith v. GTE Corp.*, 236 F.3d 1292, 1311 (11th Cir.2001) (quoting *Blab T.V. of Mobile, Inc. v. Comcast Cable Communications, Inc.*, 182 F.3d 851, 855-56 (11th Cir. 1999)).

Bolden v. Healthspring of Alabama, Inc., 2007 WL 4403588, at *4.

This reluctant approach to finding complete preemption, in violation of Congressional intent, was further emphasized by the United States Court of Appeals, Ninth Circuit, in *Ardary,* stating:

> [W]ithout clear guidance from the Supreme Court or Congress on these facts, we must

> begin with the strong presumption that Congress does not intend to pre-empt state law causes of action with a federal statute . . . We find nothing in the legislative history to suggest that the Act was designed to abolish state remedies which might exist against a private Medicare provider for torts committed during its administration of Medicare benefits pursuant to a contract with HCFA . . . We are most reluctant to adopt Aetna and Arrowest's over inclusive reading of the "arising under" language without a showing of clear and convincing evidence to overcome the strong presumption that Congress did not mean to prohibit all judicial review. . . . Contrary to Aetna and Arrowest's assertions, Bodimetric should not be taken to imply that private Medicare providers and their representatives cannot be held responsible in their individual capacity for tortuous acts committed in the context of the denial of Medicare benefits. The removal of the right to sue the private Medicare provider for its torts would result in an inequitable and substantial dilution of the rights of patients.

Id. at 501.

Not only has the improper analysis by the South Carolina Supreme Court reached a result that is contrary to Congressional intent, the result reached by the South Carolina Supreme Court, in this case, is in conflict with the federal district courts, as well as the United States Courts of Appeals, which have found that the Medicare Act does not preempt state law claims. *See Hofler v. Aetna U.S. Healthcare of*

Cal., Inc., 296 F.3d 764 (9th Cir. 2002) (holding Medicare Act does not preempt state law claims against healthcare providers); *Ardary v. Aetna Health Plans of Cal., Inc.*, 98 F.3d 496 (9th Cir. 1996) (holding administrative procedures under Medicare Act do not preempt state law claims when claims do not "arise under" the Act); *Nott v. Aetna U.S. Healthcare, Inc.*, 303 F.Supp.2d 565 (E.D.Pa.2004) (holding the Medicare Act does not preempt state law claims because (i) there is no civil enforcement scheme under Medicare to replace the state law system and (ii) the Act does not clearly express Congressional intent to preempt all state law claims); and *Palmer v. St. Joseph Healthcare P.S.O., Inc.*, 134 N.M. 405, 77 P.3d 560 (Ct. App. 2003) (holding Medicare Act does not preempt claims against health care providers under New Mexico law).

While it is clear that the South Carolina Supreme Court erred in holding that the Medicare Act preempts Decedent's state law claims, this case is not just about correcting an error committed by a state supreme court. This ruling has vastly and inappropriately expanded the scope of Medicare Act preemption to include state law claims against private physicians which are based, in part, on a violation of the Medicare regulations. Unless this erroneous decision is corrected, this ruling will be used as precedent, both in the State of South Carolina and in other states, to substantially dilute the rights and protections afforded Medicare beneficiaries. This case will be used as both binding and persuasive authority in the future and the effects of this

erroneous holding will go far beyond the litigants in this case.

The Petitioner respectfully requests this Honorable Court grant this Petition for the above stated reasons.

II. THE SOUTH CAROLINA SUPREME COURT'S RULING DENIES THE DECEDENT AND THOSE SIMILARLY SITUATED DUE PROCESS OF LAW.

Medicare beneficiaries are entitled to due process protections before the property interest they have in Medicare benefits is interrupted and, in fact, are entitled to due process protections greater than those provided other federal beneficiaries. It is clear that Congress and the federal courts have viewed access to state law remedies as part and parcel of the due process protections granted to Medicare beneficiaries. The erroneous ruling of the South Carolina Supreme Court has denied the Decedent the last and *only* avenue of due process protection available – state common law.

A social security recipient has a property right in continued receipt of benefits which is protected by the Due Process Clause of the Fifth Amendment. *See Mathews v. Eldridge*, 424 U.S. 319, 332 (1976). ("The Secretary does not contend that procedural due process is inapplicable to termination of Social Security Disability benefits. He recognizes, as has been implicit in our prior decisions, that the interest of an individual in continued receipt of these benefits is a

statutorily created 'property' interest protected by the Fifth Amendment."). The interest in continued receipt of benefits, protected by the Due Process Clause of the Fifth Amendment, has been extended to Medicare beneficiaries. This extension is set forth in *Grijalva v. Shalala*, where the United States Court of Appeals held that certain Medicare regulations did not provide Medicare beneficiaries who had been denied coverage for medical services adequate procedural protections to comply with due process.[5]

In fact, the *Grijalva* Court found that Medicare beneficiaries had a greater interest in uninterrupted receipt of benefits requiring greater due process protection than those offered Social Security benefits. The *Grijalva* Court stated, that "Plaintiffs' interest in Medicare benefits is greater than the interests of the Plaintiff in *Eldridge* . . . the mere fact that the enrollee may be able to go elsewhere and pay for the service herself is of little comfort to an elderly poor patient – particularly one who is ill and whose [benefits have] been terminated without a specific reason or description of how to appeal." *Id.* at 1121.

The need for increased due process protection before an interference or disruption of Medicare benefits has been addressed by other courts and is clearly related to the excessive cost of medical care and pharmaceuticals similar to those incurred by the Decedent in the instant case. *See Kraemer v. Heckler*,

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[5] 152 F.3d 1115 (9th Cir. 1998).

737 F.2d 214, 222 (2d Cir. 1984) ("In applying the balancing test, the private interest at stake [in the termination of Medicare coverage] should be weighed more heavily than in *Eldridge* because of the astronomical nature of medical costs."); *see also Vorster v. Bowen*, 709 F. Supp. 934, 946 (C.D. Cal. 1989) ("The private interest, in this case, is the claimant's need to obtain reimbursement for medical bills that he or she has already paid. That interest is fairly great. Congress enacted the [Medicare] program because of the special coincidence of medical needs and financial problems of the elderly . . . Denying payment for a relatively small amount of money can be very significant to a person living on a fixed income. Many small denials aggregated over a year may be substantial. The total cost of medical care to the elderly can be enormous. Clearly, there exists a substantial private interest in obtaining reimbursement for medical bills.") (internal citations omitted).

It is clear that the Decedent had an interest, protected by the Due Process Clause of the Fifth Amendment, in uninterrupted receipt of benefits. There were only two places that interest could be protected – Medicare's administrative process or the courts.

Although the actions of the Respondents shut the Decedent out of the administrative process, Congress provided for an elaborate administrative review process to assure that the Medicare beneficiary is not deprived of benefits without due process. *See* 42 U.S.C. § 405(g). This process can only begin with a claim being filed with Medicare. Once a claim is filed,

a coverage determination is made by the Secretary of Health and Human Services or his/her designee. *See* 42 C.F.R. § 405.801(a) ("The Medicare carrier makes an initial determination when request for payment for Part B benefits is submitted.") Generally, a carrier is appointed to act as the Secretary's agent for reviewing claims and making coverage determinations. *See* 42 U.S.C. § 1395u(a) ("The administration of this part shall be conducted through contracts with Medicare administrative contractors under section 1395kk-1 of this title.").

Once a coverage determination is made by the Secretary of Health and Human Services, the beneficiary is provided appeal rights in case of an adverse coverage decision. *See* 42 U.S.C. § 405.801(a) and (b) ("The rights of a beneficiary under paragraph (a) of this section to appeal the carrier's initial determination . . . "). Ultimately, those appeal rights include judicial review. "[A]ny individual dissatisfied with any initial determination . . . shall be entitled to reconsideration of the determination and . . . a hearing thereon by the Secretary . . . and . . . to **judicial review of the Secretary's final decision** after such hearing as provided for in section 405(h)." *See* 42 U.S.C. § 1395ff (emphasis added).

Looking at the administrative process established by Congress, it becomes evident that a claim filing and a coverage decision by the Secretary is the prerequisite to any administrative remedy available under the Medicare Act.

It should again be emphasized that there is no doubt that if claims had been filed in this case that the cost of the injections would have been covered by Medicare. (*See infra* App. 136, ¶ 17(c) and (d); App. 140, ¶ 19; and App. 157, ¶ 19). The Decedent's problem was that although the Respondents submitted claims every month to have Medicare pay him to inject the Decedent, the Respondents refused to submit the claims for the cost of the medication. (*See infra* App. 85, ¶ 69-70). Not only was this refusal a violation of Medicare regulations it was also a breach of the standard of care the Respondent, as a physician, owed to the Decedent, his patient. (*See infra* App. 137, ¶ 18(a), referencing *Medicare's Mandatory Claim Submission Rule*; and App. 157, ¶ 18). The Respondents did this to protect their own financial self interest because he did not want to wait for reimbursement. (*See infra* App. 85, ¶ 69 – App. 86, ¶ 75; and App. 122-130). Between May 2001 and October 2001, the Decedent repeatedly pled with the Respondents to submit the claims because he could not continue to afford the medication, at the pharmacy – medication that was an absolute necessity. All of those pleas went unanswered. (*See infra* App. 87, ¶ 78-80; and App. 88, ¶ 82). This is the basis for Decedent's state law claims. It is clear that the Respondents, in violation of Medicare regulations refused to submit claims to Medicare because he did not want to wait to be reimbursed by Medicare. This caused unnecessary economic damage to the Decedent.

Although the Respondents have repeatedly argued to the contrary, it is additionally clear that the Decedent was prohibited from submitting his own

claims to Medicare for the cost of the medication. "Effective with services furnished on or after February 1, 2001, payment for any drug covered under Part B of Medicare may be made on an assignment-related basis only." *See* 42 C.F.R. § 414.707(a)(7)(b). *See also* Medicare Program Memorandum Carriers, Transmittal B-01-10 (*See infra* App. 118, "Mandatory Assignment"). ("Under § 114 of BIPA, payment for any drug or biological covered under Part B of Medicare may be made only on an assignment-related basis."). Furthermore, "CMS [the Center for Medicare Services] **does not** accept beneficiary submitted claims for items subject to mandatory assignment." *See* Chapter One, Section 30.3.10 of the Medicare Claims Processing Manual (emphasis added) (*See infra* App. 121, ¶ 2).

Because medications under Medicare Part B are subject to mandatory assignment and because the Center for Medicare Services does not accept claims submitted by beneficiaries for items subject to mandatory assignment, the Decedent was absolutely prohibited from submitting his own claims. The violations of Medicare regulations by the physician paired with the inability of the Decedent to submit his own claims shut the Decedent completely out of Medicare's administrative process. This left only a federal or state court remedy.

The federal courts were unavailable to the Decedent. First and foremost, there was no jurisdictional basis for the Decedent to bring his claims in federal court. The Decedent had no federal cause of action. The Decedent relied entirely upon state common law alleging that the physician breached the standard of care, in part, by violating Medicare regulations. A

review of the Complaint would clearly show that the Decedent's causes of action would not have supported federal question jurisdiction. (*See infra* App. 69 and App. 112).

Moreover, the federal courts lacked jurisdiction because there was no coverage decision for the federal courts to review. Federal jurisdiction in matters such as this is limited to a review of the "findings and decisions" of the Secretary related to coverage. *See* 42 U.S.C. § 405(h). *See also* 42 U.S.C. § 1395ff. (A beneficiary "may obtain a review of such **decision** by a civil action commenced within sixty days . . . Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides . . . As part of the [Secretary's] answer the [Secretary] . . . shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The Court shall have the power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing **the decision of the [Secretary]**, with or without remanding the cause for rehearing.") (emphasis added). *See* 42 U.S.C. § 405(g). Without a claim being filed there was no "finding or decision" of the Secretary of Health and Human Services that the federal courts could review.

This jurisdictional limitation is explained in *Della Dial v. Healthspring of Alabama, Inc.*, 541 F.3d 1044, 1047 (C.A. 11 (Ala.) 2008) ("In place of that primary federal-question jurisdiction, the [Medicare] Act provides for an administrative hearing before the

Secretary of the Department of Health and Human Services. 42 U.S.C. § 1395w-22(g)(5)). If the amount in controversy is sufficient, the Act provides for **'judicial review of the Secretary's final decision'** in the form of a civil action in federal district court **against the Secretary.**") (emphasis added).

This jurisdictional limitation is additionally noted by the United States District Court for the Northern District of Georgia. "[T]he Court is not authorized to address claims against the United States, the Secretary of Health and Human Services, or their officers and employees, that arise under the Medicare Act until after the conclusion of an administrative review process . . . Plaintiff's do not assert claims against the United States, the Secretary of Health and Human Services, or their officers or employees. Furthermore, the Medicare Act contains no administrative review process that applies to Plaintiff's claims." *Brogdon, supra* at 1328. Just as in *Brogdon*, the Decedent in the instant case does not assert claims against the United States, the Secretary of Health and Human Services or their officers or employees. More importantly, the Medicare Act contains no administrative process that would apply to Decedent's claims against the Respondents for negligence and breach of fiduciary duty. It is clear that the federal courts provided the Decedent no avenue of due process, leaving only the South Carolina courts.

The South Carolina Supreme Court, by and through its inaccurate ruling, closed the last remaining avenue of remedy available to the Decedent –

state common law. Its ruling is based not on independent state grounds but rather based entirely upon its inaccurate interpretation of a federal statute, believing that § 405(h) preempts Decedent's state law claims.

Congress, understanding the importance of Medicare coverage, set up an elaborate administrative system to make sure that any denial or termination of Medicare benefits was reviewed by and through a procedure that comported with due process requirements. Congress went so far as to vest the federal courts of this country with jurisdiction to review the decisions of the Secretary of the United States Department of Health and Human Services. The federal courts have elaborated upon and discussed the property interest of the Medicare beneficiary in Medicare benefits and the requirement of a procedure that comports with due process prior to any termination or interference with those benefits. Given all of these protections, it is incomprehensible to believe that Congress could have intended to completely preempt state law negligence claims brought by a Medicare beneficiary against a private physician who, based on financial self interest, interfered with and ultimately blocked the beneficiary's ability to receive Medicare benefits for Medicare covered injections.

The Decedent and the Estate, by and through the erroneous decision of the South Carolina Supreme Court, have been left to suffer a wrong without a remedy and, therefore, a denial of their due process

rights. This cannot be what Congress intended. Rather, Congress intended the state courts to remain available to Medicare beneficiaries to protect the Medicare beneficiary's property interest in continued receipt of benefits. The South Carolina Supreme Court, by closing this door with no reason other than its erroneous application of § 405(h) has denied the Decedent due process of law.

This case, unless reviewed and corrected, will be used to defend every Medicare provider that chooses to turn their back on the rules and whose actions, whether under Medicare Part B or Part D, completely shut elderly beneficiaries out of the system. More importantly, it will be used to deny every Medicare beneficiary who faces the same difficulties the Decedent encountered in the final months of his life, "[t]he fundamental requirement of due process ... the opportunity to be heard at a meaningful time and in a meaningful manner" before they are completely denied their Medicare benefits. *Eldridge*, *supra* at 902.

The Petitioner respectfully requests this Honorable Court grant this Petition for the above stated reasons.

III. IF THE SOUTH CAROLINA SUPREME COURT'S RULING IS BASED ON AN INDEPENDENT STATE LAW GROUND, IT HAS DENIED THE DECEDENT AND THOSE SIMILARLY SITUATED EQUAL PROTECTION OF THE LAWS.

If it is determined that the South Carolina Supreme Court used an independent state law ground to support the dismissal of Decedent's negligence and breach of fiduciary duty claims seeking economic damages, which is denied, that ruling violates the concepts of equal protection. If based on independent state law grounds, the South Carolina Supreme Court has provided no rational basis to differentiate between negligence plaintiffs who support their negligence claim on a violation of federal regulations and who are permitted to collect economic damages and those negligence plaintiffs, like the Decedent, who rely on a violation of federal regulations and who are not permitted to collect economic damages.

"'[T]he purpose of the equal protection clause of the Fourteenth Amendment is to secure every person within the State's jurisdiction against intentional and arbitrary discrimination, whether occasioned by express terms of a statute or by its improper execution through duly constituted agents.'" *Village of Willowbrook v. Olech*, 528 U.S. 562, 564 (2000) (citing *Sioux City Bridge Co. v. Dakota County*, 260 U.S. 441, 445 (1923) (quoting *Sunday Lake Iron Co. v. Township of Wakefield*, 247 U.S. 350, 352 (1918)).

This Honorable Court's "decision in *Village of Willowbrook v. Olech*, 528 U.S. 562 (2000) (*per curiam*), applied a rule that had been an accepted part of our equal protection jurisprudence for decades: Unless state action that intentionally singles out an individual, or a class of individuals, for adverse treatment is supported by some rational justification, it violates the Fourteenth Amendment's command that no State shall 'deny to any person within its jurisdiction the equal protection of the laws.'" *Engquist v. Oregon Dept. of Agriculture*, 128 S. Ct. 2146, 2158 (2008). (Stevens, J., dissenting, joined by Souter, J., and Ginsberg, J.).

The ruling of the South Carolina Supreme Court, if based on an independent state law ground, has the effect of denying members of the same class, those who bring state negligence claims, equal treatment. This ruling limits the types of damages certain members of that class are able to recover without a rational basis for making that distinction. A South Carolina negligence Plaintiff can recover both non-economic and economic damages in a state law claim; however, based on this ruling, a South Carolina negligence plaintiff who happens to be a Medicare beneficiary and who supports, in part, the negligence claim on a violation of Medicare regulations, is denied that same opportunity to collect economic damages.

The South Carolina Supreme Court has found that a negligence claim can be supported by a violation of Medicare regulations. (*See infra* App. 10,

FN 6). There is uncontradicted evidence in the record to show that the Respondents violated at least two (2) Medicare regulations (*See infra* App. 137, ¶ 18(a), referencing *Medicare's Mandatory Claim Submission Rule*). Additionally, there is uncontradicted evidence in the record to show that the Respondents, by and through these violations, breached the standard of care owed to the Decedent. (*See infra* App. 156, ¶ 16(m); and App. 157, ¶ 18). Finally, it is clear that the Decedent suffered economic loss as a result of those violations. The Estate should be able to recover the economic damages the Decedent suffered as a result of the violations of Medicare regulations by the Respondents just as any other negligence plaintiff is able to collect those damages.

There can be no doubt that South Carolina law permits the recovery of economic damages in negligence claims. *See Weaver v. Lentz*, 348 S.C. 677, 561 S.E.2d 360 (S.C. Ct. App. 2002) (Testimony of economics expert was admissible, in wrongful death action against physician, to prove **loss of decedent's future earnings**.) (emphasis added). *See also Hundley ex rel. Hundley v. Rite Aid of South Carolina, Inc.*, 339 S.C. 285, 529 S.E.2d 45 (S.C. Ct. App. 2000) (Economist who testified on behalf of parents properly relied on life care plan to render expert opinion as to **economic damages**, consisting of the present value of future medical and related costs, sustained by parents for child's permanent brain damage that was caused by an incorrectly filled prescription.) (emphasis added); *Pearson v. Bridges*, 337 S.C. 524, 524 S.E.2d 108 (S.C. Ct. App. 1999) ("Most probable"

standard for admissibility did not apply to evidence concerning patient's **future medical expenses** in medical malpractice action; rather, correct standard was that such evidence be beyond speculation or conjecture and reasonably certain to occur.) (emphasis added); *Clark v. South Carolina Dept. of Public Safety*, 362 S.C. 377, 608 S.E.2d 573 (2005) ("Furthermore, pecuniary loss is only one of six elements to be considered in awarding damages in a wrongful death action."). This rule of law should be applied equally to all state law negligence plaintiffs regardless of whether the claims are supported, in part, on a violation of Medicare regulations.

The ruling of the South Carolina Supreme Court has the effect of denying the Decedent and those similarly situated, who seek recovery of economic damages through a state law negligence claim relying, in part, on a violation of Medicare regulations, access to the courts to recover those economic damages. The South Carolina Supreme Court has provided no rational basis making this distinction.

If it is determined that the South Carolina Supreme Court had an independent state law ground to dismiss the Decedent's economic claims, which is denied, this Honorable Court should review that decision as it clearly violates concepts of equal protection guaranteed by the Fourteenth Amendment.

CONCLUSION

The South Carolina Supreme Court erred in finding that the Decedent's state law claims were preempted by the Medicare Act. The Decedent brought state law claims against a private physician who, based on financial self interest, interfered with and ultimately blocked the beneficiary's ability to receive Medicare benefits for Medicare covered injections. The actions of the Respondents were not only a violation of Medicare regulations but also the standard of care and those actions caused economic damage to the Decedent. Contrary to the ruling of the South Carolina Supreme Court, 42 U.S.C. § 405(h) provides no basis to support the dismissal of Decedent's state law claims.

This Petition, however, should not be viewed as a simple request to correct a state's highest court. The erroneous expansion of Medicare Act preemption by the South Carolina Supreme Court has effects far beyond the impact to the instant litigants. The holding of the South Carolina Supreme Court can be used as binding precedent to impact Medicare beneficiaries' ability to receive benefits under all Medicare parts, including Medicare's Part D prescription coverage.[6] The practical effect of this holding informs

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[6] Enacted as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). See Pub. L. No. 106-554.

all physicians in South Carolina that they will incur no liability for placing their own financial interests above the interests of their patients who are Medicare beneficiaries. With guidance from this case, they can refuse to submit claims to Medicare, in violation of Medicare regulations, and as long as they cause only economic damage to the Medicare beneficiary they will incur no liability.

More concerning than the moral hazard caused by this ruling is that fact that this ruling removes the last process available to the Medicare beneficiary to address a wrong committed upon them by a physician who, based on financial self interest, interferes with and ultimately blocks the beneficiary's ability to receive Medicare benefits. This ruling will force Medicare beneficiaries to either forgo the benefit of life saving medications or suffer the economic loss of purchasing the medication out-of-pocket. After foregoing the medication or suffering the economic loss, this ruling will also block that Medicare beneficiary from pursuing his last and only hope to remedy such a wrong – a court of law. These beneficiaries will be, just as the decedent was, left to suffer a wrong without a remedy, thereby substantially diluting their congressionally provided rights and protections.

The Petitioner respectfully requests that this Honorable Court grant this petition and review the important federal issues involved in this case.

Respectfully submitted,

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January 7, 2009

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THE STATE OF SOUTH CAROLINA
In The Supreme Court

Phyllis J. Wogan, individually
and as Personal Representative
of the Estate of James J. Wogan, Petitioner,

v.

Kenneth C. Kunze, M.D.;
Hilton Head Gastroenterology,
P.A.; Thomas P. Rzecycki,
M.D.; Hilton Head General and
Laparoscopic Surgery, P.A.;
Gary W. Thomas, M.D.; and
Gary W. Thomas M.D., P.A., Respondents.

ON WRIT OF CERTIORARI
TO THE COURT OF APPEALS

Appeal From Beaufort County
Curtis L. Coltrane, Circuit Court Judge

Opinion No. 26542
Heard May 7, 2008 – Filed September 8, 2008

AFFIRMED AS MODIFIED

Samuel S. Svalina and Jennifer I. Campbell, both of Svalina Law Firm, of Beaufort; and Timothy M. Wogan, of Hilton Head Island, for Petitioner.

Elliott T. Halio and Andrew S. Halio, both of Halio & Halio, of Charleston; and Mary Bass Lohr and James S. Gibson, Jr., both of Howell Gibson & Hughes, of Beaufort, for Respondents.

Frederick A. Crawford and Anthony E. Rebollo, both of Richardson, Plowden & Robinson, of Columbia, for Amicus Curiae SC Association of Certified Public Accountants.

Johannes S. Kingma and John C. Rogers, of Atlanta, and Lenna S. Kirchner, of Carlock Copeland Semier & Stair, of Charleston, for Amicus Curiae Abram Serotta & Serotta, Maddocks, Evans & Co.

JUSTICE WALLER: We granted a writ of certiorari to review the Court of Appeals' opinion in *Wogan v. Kunze,* 366 S.C. 583, 623 S.E.2d 107 (Ct. App. 2005). We affirm the grant of summary judgment in favor of Dr. Kunze, as modified.

FACTS

Petitioner's husband, James J. Wogan, was diagnosed with rectal cancer in 1997 and was treated with chemotherapy by an oncologist, Dr. Thomas. Mr. Wogan developed a very severe case of diarrhea, resulting in malnutrition and dehydration, for which

he was referred to Respondent, Dr. Kunze, a gastroenterologist. A colostomy was performed to stop the diarrhea but did not remedy the problem. Dr. Kunze placed Wogan on the drug Sandostatin SC, which was inserted subcutaneously three times a day and was not covered by Medicare. Sandostatin SC stopped the diarrhea within a few days.

A few weeks later, Dr. Kunze suggested Mr. Wogan try a new drug, Sandostatin LAR, which could be administered monthly, and was, according to Wogan's complaint, covered by Medicare. Dr. Kunze refused to pre-order the Sandostatin LAR and administer it in his office because he did not believe it was covered by Medicare unless the diarrhea was caused by the chemotherapy. The chemotherapist, Dr. Thomas, was of the opinion that it was not covered. Dr. Thomas also refused to prescribe and administer the medication. Dr. Kunze ultimately agreed to administer the Sandostatin LAR, but he required the Wogans to purchase the monthly doses directly from a pharmacy.

The Wogans purchased Sandostatin LAR at a cost of $2000 per month for three months.[1] Neither Dr. Kunze nor Dr. Thomas would assist them with filing a Medicare claim. Mr. Wogan died in October 2001.

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[1] The Wogans paid approximately $1,278 a month for Sandostatin SC; they paid approximately $2,094 a month for Sandostatin LAR.

Mrs. Wogan filed this action against Dr. Kunze and others, alleging (1) negligence based on both medical malpractice from the surgery and Dr. Kunze's failure to file Medicare claims for the Sandostatin LAR; (2) breach of Dr. Kunze's contract with Medicare under which it was alleged Mr. Wogan was a third-party beneficiary; (3) violations of the South Carolina Unfair Trade Practices Act (UTPA); (4) breach of fiduciary duty in failing to file the Medicare claim; and (5) loss of consortium.

The trial court granted partial summary judgment to Dr. Kunze, holding Mrs. Wogan could not assert a state law negligence claim based on Kunze's failure to comply with a federal act, where the federal act (Medicare Act) did not allow a private right of action. The trial court further rejected Wogan's breach of fiduciary duty claim, finding the only breaches alleged (medical malpractice and failure to file a claim) had been alleged in the negligence cause of action. The Court of Appeals affirmed.[2]

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[2] The claims for violation of the UTPA and breach of third party beneficiary contract were also dismissed, as were the claims against Dr. Thomas. No issue is raised on certiorari regarding these claims.

ISSUES[3]

1. Did the Court of Appeals err in affirming the trial court's ruling that Wogan could not maintain a state negligence claim against Dr. Kunze based upon his failure to file the Medicare claim?

2. Was summary judgment properly granted on the breach of fiduciary duty claim?

STANDARD OF REVIEW

When reviewing the grant of summary judgment, this Court applies the same standard which governs the trial court under Rule 56(c), SCRCP: summary judgment is proper when there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. *Fleming v. Rose,* 350 S.C. 488, 493, 567 S.E.2d 857, 860 (2002). In determining whether triable issues of fact exists, the evidence and all factual inferences must be viewed in the light most favorable to the nonmoving party. *Sauner v. Pub. Serv. Auth.,* 354 S.C. 397, 404, 581 S.E.2d 161, 165 (2003). If evidentiary facts are not disputed but the conclusions or inferences to be drawn from them are, summary judgment should be denied. *Baugus v. Wessinger,* 303 S.C. 412, 415, 401 S.E.2d 169, 171 (1991). The purpose of summary judgment is to expedite disposition of cases which do

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[3] In light of our holding, we need not address Wogan's remaining issue.

not require the services of a fact finder. *George v. Fabri,* 345 S.C. 440, 548 S.E.2d 868 (2001).

1. NEGLIGENCE[4]

Wogan contends the Court of Appeals erred in affirming the grant of summary judgment to Dr. Kunze. She asserts liability is based, not on a violation of the Medicare Act,[5] but upon a violation of the standard of care of a reasonable physician. Wogan claims it was a breach of the standard of care for Dr. Kunze to refuse to file a Medicare claim on her behalf. The trial court and Court of Appeals held that, inasmuch as there is no right of action under the Medicare Act, Wogan could not base her state law claim on Dr. Kunze's failure to file such a claim. We agree with the result reached in this case; however, we find the Court of Appeals' holding overly broad.

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[4] The underlying medical malpractice claims remain pending against Dr. Kunze.

[5] Wogan does not contest the fact that case law generally holds there is no private right or action under the Medicare Act. *See Brogdon v. Nat'l Healthcare Corp.*, 103 F.Supp.2d 1322, 1340 (N.D.Ga.2000) (Congress did not intend to create a private right of action when it enacted the Medicare and Medicaid Acts and authorized their accompanying regulations); *Abner v. Mobile Infirmary Hospital*, 149 Fed. Appx. 857 (11th Cir. 2005) (noting that Medicare Act does not create a private right of action for negligence); *Ratmansky ex rel. Ratmansky v. Plymouth House Nursing Home, Inc.*, 2005 WL 770628 (E.D.Pa. 2005) (Medicare Act and regulations do not create a private right of action against nursing home).

Contrary to the Court of Appeals' ruling, there are some circumstances in which a state law negligence claim may be maintained against a third party as a result of the denial of Medicare benefits. The United States Supreme Court addressed this issue peripherally in *Heckler v. Ringer,* 466 U.S. 602, 615 (1984). *Heckler* involved a suit brought by three people who were denied reimbursement for bilateral carotid body resection (BCBR) surgery and one person who declined the surgery because he was unable to pay for it. They brought an action challenging the Secretary of Health and Human Services' ruling that the surgery was neither reasonable nor necessary. Although the case involved the issue of whether the plaintiffs could maintain suit in federal court, or were first required to exhaust their administrative remedies via review pursuant to 42 USC § 405(g) of the Medicare Act, the Supreme Court held "[I]t seems to us that it makes no sense to construe the claims of those three respondents as anything more than, at bottom, a claim that they should be paid for their BCBR surgery." 466 U.S. at 614. Accordingly, the Court held that because the plaintiffs' claims were "inextricably intertwined" with their claim for benefits, that they were required to proceed under the Medicare Act. The Court recognized that there may be an exception in certain special cases where claims are "wholly collateral" to a claim for benefits under the Act, or where there is a colorable claim that an erroneous **"denial of benefits in the early stages of the administrative process will injure them in a way that cannot be remedied by the later**

payment of benefits." 466 U.S. at 618 (emphasis supplied).

An example of such an exception was demonstrated in *Ardary v. Aetna Health Plans of California, Inc.* 98 F.3d 496 (9th Cir. 1996), *cert. denied* 520 U.S. 1251 (1997). There, the decedent suffered a heart attack and was taken to a small, rural hospital near her home, which had neither intensive care nor cardiac facilities. The decedent's husband requested she be air-lifted to Loma Linda University Medical Center, a larger and better equipped facility, but the request was denied, and Mrs. Ardary died. Ardary filed a wrongful death suit alleging Mrs. Ardary died because of the failure to authorize an airlift to Loma Linda. The Ninth Circuit held the plaintiffs' claims were state common law claims, which were not "inextricably intertwined" with the denial of benefits. *Ardary,* 498 F.3d at 500. The court found that, "[a]lthough the Ardarys . . . wrongful death complaint is predicated on Aetnowest's failure to authorize the airlift transfer, the claims are not 'inextricably intertwined' because the Ardarys are **at bottom not seeking to recover benefits.**" *Id.* (emphasis supplied). *But see Biometric Health Services v. Aetna,* 903 F.2d 480 7th Cir. (1990) (party cannot avoid Medicare Act's jurisdictional bar simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits; if litigants may routinely obtain judicial review of these decisions by recharacterizing their claims under state causes of action, the Medicare Act's goal of limited judicial

review for a substantial number of claims would be severely undermined).

Heckler has been interpreted as "sweeping within the administrative review process only those claims that, at bottom, seek reimbursement or payment for medical services." *McCall v. PacificCare of Cal.*, 21 P.3d 1189, 1199 (Calif.), *cert denied* 535 U.S. 951 (2001) *See also Regional Medical Transport Inc. v. Highmark Inc.*, ___ F.Supp2d ___, 2008 WL 872255 (E.D. Pa. 2008) (in assessing whether a claim falls into this category, courts must discount any "creative pleading" which may transform Medicare disputes into mere state law claims, and painstakingly determine whether such claims are ultimately Medicare disputes).

Accordingly, contrary to the Court of Appeals" opinion, whether a state common law action for negligence may be maintained depends, under *Heckler* and subsequent cases, on whether or not the plaintiff's claims are, at bottom, a claim seeking payment of reimbursement of sums which are alleged to be covered by Medicare, or whether the claims are wholly independent, but nonetheless stemming from the failure to provide some type of Medicare service. To the extent the Court of Appeals' opinion fails to acknowledge the possibility of a state law claim, it is hereby modified.

However, we concur with the result reached by the Court of Appeals. Although Wogan characterizes her cause of action as a state law claim for negligence, it is,

at bottom, a claim for reimbursement of the $2000 per month which was expended on Sandostatin LAR prior to Mr. Wogan's death. Her claim is therefore "inextricably intertwined" with the refusal to file a Medicare claim and is therefore not cognizable on state law negligence grounds.[6] The grant of summary judgment to Dr. Kunze is affirmed.

2. BREACH OF FIDUCIARY DUTY

Wogan also asserts the trial court erred in granting summary judgment on her claim for breach of fiduciary duty. Once again, the underlying basis of the breach of fiduciary duty claim is that Wogan seeks reimbursement of the expenses she suffered by having to pay for the Sandostatin LAR for three months out-of-pocket. Pursuant to *Heckler* and *Ardary*, we find Wogan's claim is **at bottom** an attempt to recover monies which would otherwise have been paid by Medicare. Since such a claim is not cognizable

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[6] We agree with Wogan's contention that the violation of a statute or regulation may, in a proper case, be used as evidence of negligence. *See e.g.*, *Wise v. Broadway*, 315 S.C. 273, 433 S.e.2d 857 (1993); *Daniels v. Bernard*, 270 S.C. 51, 240 S.E.2d 518 (1978); *Shearer v. DeShon*, 240 S.C. 472, 126 S.E.2d 514 (1962) (causative violation of a statute constitutes negligence per se). Violation of a Medicare statute could conceivably be used to support of a state negligence claim where the state law claim is not inextricably intertwined with a claim for Medicare reimbursement. For example, in *Ardary*, the plaintiffs would be entitled to demonstrate that the defendant's failure to authorize an airlift to the regional hospital violated a Medicare statute or regulation, thereby causing Mrs. Ardary's untimely death.

as an independent state negligence claim, it was properly dismissed.

The Court of Appeals' opinion is

AFFIRMED AS MODIFIED.

TOAL, C.J., MOORE, PLEICONES and BEATTY, JJ., concur.

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

Phyllis J. Wogan, individually and as Personal Representative of the Estate of James J. Wogan,

v. **Appellant,**

Kenneth C. Kunze, M.D.; Hilton Head Gastroenterology, PA.; Thomas P. Rzecycki, M.D.; Hilton Head General and Laparoscopic Surgery, P.A.; Gary W. Thomas, M.D.; and Gary W. Thomas M.D., P.A., **Respondents.**

Appeal From Beaufort County
Curtis L. Coltrane, Special Circuit Court Judge

Opinion No. 4026
Heard September 14, 2005 –
Filed September 26, 2005

AFFIRMED

I. McDuffie Stone, III, of Bluffton and Timothy M. Wogan, of Hilton Head Island, for Appellant.

Elliott T. Halio, and Andrew S. Halio, both of Charleston and James S. Gibson, Jr., of Beaufort, for Respondents.

ANDERSON, J.: Phyllis J. Wogan, individually and as Personal Representative of the Estate of James J. Wogan, initiated this action for negligence, loss of consortium, breach of third-party beneficiary contract, breach of fiduciary duty, and violations of the South Carolina Unfair Trade Practices Act. The trial court granted summary judgment to Kenneth C. Kunze, M.D.; Hilton Head Gastroenterology, P.A.; Gary W. Thomas, M.D.; and Gary W. Thomas M.D., P.A.[1] (collectively "the Doctors") on the claims for unfair trade practices, breach of fiduciary duty, breach of a third-party beneficiary contract, and a portion of the negligence cause of action based upon their alleged failures to file Medicare claims. We affirm.

FACTUAL/PROCEDURAL BACKGROUND

Dr. Thomas administered chemotherapy to treat Mr. Wogan for rectal cancer. By the end of the chemotherapy, Mr. Wogan had developed a severe case of high output/high frequency diarrhea. The diarrhea

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[1] The two remaining Respondents are not involved in this appeal.

caused malnutrition and dehydration, and consequently led to several hospitalizations. Mr. Wogan was referred to Dr. Kunze for treatment of the gastrointestinal problem. Dr. Kunze performed a colostomy in order to stop the diarrhea. Unfortunately, the procedure did not remedy the problem. The ordering and performance of this procedure makes up a portion of the medical malpractice action not subject to this appeal.

Dr. Kunze placed Mr. Wogan on the drug Sandostatin SC to alleviate his diarrheic condition. After determining the drug was effective at controlling the diarrhea, Dr. Kunze informed the Wogans he would switch the prescription to Sandostatin LAR. Sandostatin SC was inserted subcutaneously three times a day and was not covered by Medicare. Sandostatin LAR is a long-acting version that would need to be injected once a month. Ms. Wogan alleged Medicare would cover the drug if the diarrhea resulted from Mr. Wogan's chemotherapy.

According to Ms. Wogan, Dr. Kunze originally indicated he would preorder the Sandostatin LAR, administer it in his office, and submit the claim to Medicare. Later, Dr. Kunze notified Ms. Wogan he would not preorder the drug. Dr. Kunze's nurse suggested that Ms. Wogan consult with Dr. Thomas to see if he would prescribe and administer the medication, but Dr. Thomas would not, and represented he did not believe the diarrhea resulted from the chemotherapy. Eventually, Dr. Kunze agreed to administer the Sandostatin LAR, but required Ms. Wogan to

purchase the monthly doses from a pharmacy. He refused to file a Medicare claim for the drug. The Wogans purchased Sandostatin LAR at a cost of $2000 per month for several months, and continued to insist either Dr. Kunze or Dr. Thomas assist with a Medicare claim.

Mr. Wogan's debilitating diarrhea persisted and resulted in several hospitalizations. During one hospital stay, Dr. Thomas ordered Mr. Wogan to continue taking all prescribed medications, including the Sandostatin, but he did not actually write a prescription for the Sandostatin. Mr. Wogan died in October 2001.

Originally, Ms. Wogan filed this action against Kenneth C. Kunze, M.D.; Hilton Head Gastroenterology, P.A.; Thomas P. Rzecycki, M.D.; Hilton Head General and Laparoscopic Surgery, P.A. A year and a half later, Gary W. Thomas, M.D. and Gary W. Thomas M.D., P.A., were added as parties. The complaint asserts claims for (1) negligence based on both medical malpractice from the surgery and failures by the Doctors to file claims or help Ms. Wogan file a claim with Medicare for the Sandostatin LAR; (2) breaches of the Doctors' contracts with Medicare under which it was alleged Mr. Wogan was a third-party beneficiary; (3) violations of the South Carolina Unfair Trade Practices Act; (4) breaches of fiduciary duty by the Doctors in failing to file the Medicare claim; and (5) loss of consortium.

The Doctors filed motions for summary judgment on all but the medical malpractice and loss of consortium claims. In their memoranda submitted to the court, they contend there is no private right of action provided in the Medicare statute, and Ms. Wogan's complaint for negligence regarding their failures to file Medicare claims was merely a claim for violation of the Medicare Act. Additionally, the Doctors maintained the action for unfair trade practices must fail because the medical field is a regulated industry. Finally, they argued there was no fiduciary duty to file the claim. Dr. Thomas contended he could not be found negligent because he never actually prescribed the medicine; thus, it would have been fraud had he submitted a claim to Medicare.

The trial court agreed with the Doctors and granted summary judgment as to the negligence action based on the failure to file a Medicare claim. The court found there is no private right of action, either expressed or implied, in the Medicare Act. Furthermore, the court ruled Ms. Wogan could not use a state law claim to assert an action based on the Doctors' failure to follow a federal act when the act does not provide for a private right of action.

According to the court, Ms. Wogan could not maintain her suit for unfair trade practices because as an individual she did not demonstrate an ascertainable loss, and the statute prohibits her from bringing a claim in a representative capacity. The court further rejected the breach of fiduciary duty claim because the only breaches alleged were for

medical malpractice and failure to file a claim – both of which Ms. Wogan alleged in her negligence cause of action. Finally, the court concluded the allegations against Dr. Thomas failed, as he never prescribed the medicine, and therefore, had no duty to file a Medicare claim. Ms. Wogan's motion for reconsideration was denied.

STANDARD OF REVIEW

When reviewing the grant of a summary judgment motion, the appellate court applies the same standard which governs the trial court under Rule 56(c), SCRCP: summary judgment is proper when there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. *Pittman v. Grand Strand Entm't, Inc.*, 363 S.C. 531, 611 S.E.2d 922 (2005); *B & B Liquors, Inc. v. O'Neil*, 361 S.C. 267, 603 S.E.2d 629 (Ct. App. 2004). In determining whether any triable issue of fact exists, the evidence and all inferences which can reasonably be drawn therefrom must be viewed in the light most favorable to the nonmoving party. *Medical Univ. of South Carolina v. Arnaud*, 360 S.C. 615, 602 S.E.2d 747 (2004); *Rife v. Hitachi Constr. Mach. Co., Ltd.*, 363 S.C. 209, 609 S.E.2d 565 (Ct. App. 2005). If triable issues exist, those issues must go to the jury. *Mulherin-Howell v. Cobb*, 362 S.C. 588, 608 S.E.2d 587 (Ct. App. 2005).

Summary judgment is appropriate if the pleadings, depositions, answers to interrogatories, and

admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. Rule 56(c), SCRCP; *Helms Realty, Inc. v. Gibson-Wall Co.*, 363 S.C. 334, 611 S.E.2d 485 (2005); *BPS, Inc. v. Worthy*, 362 S.C. 319, 608 S.E.2d 155 (Ct. App. 2005). On appeal from an order granting summary judgment, the appellate court will review all ambiguities, conclusions, and inferences arising in and from the evidence in a light most favorable to the non-moving party below. *Willis v. Wu*, 362 S.C. 146, 607 S.E.2d 63 (2004); *see also Schmidt v. Courtney*, 357 S.C. 310, 592 S.E.2d 326 (Ct. App. 2003), *cert. denied* (Apr. 7, 2005) (stating that all ambiguities, conclusions, and inferences arising from the evidence must be construed most strongly against the moving party).

Summary judgment is not appropriate where further inquiry into the facts of the case is desirable to clarify the application of the law. *Gadson v. Hembree*, 364 S.C. 316, 613 S.E.2d 533 (2005); *Montgomery v. CSX Transp., Inc.*, 362 S.C. 529, 608 S.E.2d 440 (Ct. App. 2004). Even when there is no dispute as to evidentiary facts, but only as to the conclusions or inferences to be drawn from them, summary judgment should be denied. *Nelson v. Charleston County Parks & Recreation Comm'n*, 362 S.C. 1, 605 S.E.2d 744 (Ct. App. 2004). However, when plain, palpable, and indisputable facts exist on which reasonable minds cannot differ, summary judgment should be

granted. *Ellis v. Davidson*, 358 S.C. 509, 595 S.E.2d 817 (Ct. App. 2004).

The party seeking summary judgment has the burden of clearly establishing the absence of a genuine issue of material fact. *McCall v. State Farm Mut. Auto. Ins. Co.*, 359 S.C. 372, 597 S.E.2d 181 (Ct. App. 2004). Once the party moving for summary judgment meets the initial burden of showing an absence of evidentiary support for the opponent's case, the opponent cannot simply rest on mere allegations or denials contained in the pleadings. *Regions Bank v. Schmauch*, 354 S.C. 648, 582 S.E.2d 432 (Ct. App. 2003). Rather, the nonmoving party must come forward with specific facts showing there is a genuine issue for trial. *Rife*, 363 S.C. at 214, 609 S.E.2d at 568.

The purpose of summary judgment is to expedite disposition of cases which do not require the services of a fact finder. *Dawkins v. Fields*, 354 S.C. 58, 580 S.E.2d 433 (2003); *Rumpf v. Massachusetts Mut. Life Ins. Co.*, 357 S.C. 386, 593 S.E.2d 183 (Ct. App. 2004). Because it is a drastic remedy, summary judgment should be cautiously invoked to ensure that a litigant is not improperly deprived of a trial on disputed factual issues. *Helena Chem. Co. v. Allianz Underwriters Ins. Co.*, 357 S.C. 631, 594 S.E.2d 455 (2004); *Hawkins v. City of Greenville*, 358 S.C. 280, 594 S.E.2d 557 (Ct. App. 2004).

LAW/ANALYSIS

Ms. Wogan contends the trial court erred in granting summary judgment to the Doctors on four of her claims. She maintains her negligence action is not based upon the Medicare Act, but upon state law claims. Additionally, she contends she should not be barred from bringing the causes of action for breach of a third-party beneficiary contract, unfair trade practices, and breach of fiduciary duty. We disagree.

I. Medicare Act

A. Background

First, we address the issue of whether there is an express or implied right of action under the Medicare Act, 42 U.S.C.A. §1395. We find there is no right of action, either express or implied, relating to the failure of a physician to file a claim under 42 U.S.C.A. § 1395w-4(g)(4)(A).

The portion of the Medicare Act requiring submission of claims by physicians states:

> (4) Physician submission of claims
>
> (A) In general
>
> For services furnished on or after September 1, 1990, within 1 year after the date of providing a service for which payment is made under this part on a reasonable charge or fee schedule basis, a physician, supplier, or other person (or an employer or facility in the

cases described in section 1395u(b)(6)(A) of this title) –

(i) shall complete and submit a claim for such service on a standard claim form specified by the Secretary to, the carrier on behalf of a beneficiary, and

(ii) may not impose any charge relating to completing and submitting such a form.

(B) Penalty

(i) With respect to an assigned claim wherever a physician, provider, supplier or other person (or an employer or facility in the cases described in section 1395u(b)(6)(A) of this title) fails to submit such a claim as required in subparagraph (A), the Secretary shall reduce by 10 percent the amount that would otherwise be paid for such claim under this part.

(ii) If a physician, supplier, or other person (or an employer or facility in the cases described in section 1395u(b)(6)(A) of this title) fails to submit a claim required to be submitted under subparagraph (A) or imposes a charge in violation of such subparagraph, the Secretary shall apply the sanction with respect to such a violation in the same manner as a sanction may be imposed under section 1395u(p)(3) of this title for a violation of section 1395u(p)(1) of this title.

42 U.S.C.A. § 1395 w-4(g)(4).

Ms. Wogan concedes there is no *express* provision in the Act allowing her to sue the physicians for failing to file a claim. The Act provides for penalties and sanctions, but no private cause of action. Therefore, we must determine whether an *implied* right of action for failing to file a claim exists.

B. Other Jurisdictions

Although several federal courts have confronted the question whether the Medicare Act gives rise to an implied right of action, neither the state nor the federal courts in South Carolina have decided the issue. One case from a South Carolina Federal District Court stated the issue without answering it: " . . . this court expresses no opinion on the question of whether a private cause of action in favor of the Medicare recipients themselves could be implied under U.S.C. s 1395a." *Home Health Servs. Inc. v. Currie*, 531 F.Supp. 476 (D.S.C. 1982), *aff'd* 706 F.2d 497 (4th Cir. 1983). The *Currie* case, however, is of no help as it lucidly expresses no opinion whether or not a private cause of action may be implied under the Medicare Act.

A federal court in Florida opined:

> Congress has not, statutorily, provided any private federal right of action or remedy under the Medicare or Medicaid Acts. *See* 42 U.S.C. §§ 1395, 1396. Even if the Medicare and Medicaid Acts created some substantive

> rights, the statutes contain "numerous provisions short of judicial enforcement that are designed to redress recipients' grievances." *See Stewart v. Bernstein*, 769 F.2d 1088, 1093 (5th Cir. 1985). Congress did not intend to provide a private right of action under the Medicare or Medicaid Acts[.]

Estate of Ayres ex rel. Strugnell v. Beaver, 48 F.Supp.2d 1335, 1339-40 (M.D.Fla. 1999).

In *Brogdon ex rel. Cline v. National Healthcare Corp.*, 103 F.Supp.2d 1322 (N.D.Ga. 2000), the court was presented with the question "whether Congress intended to authorize nursing home residents to file suit against nursing homes to enforce the standards required for participation in the Medicare and Medicaid programs." *Id.* at 1330. The court concluded "Congress did not intend to create such a remedy"[:]

> The great majority of courts have determined that the Medicare and Medicaid Acts do not authorize private causes of action against nursing homes. *See Wheat v. Mass*, 994 F.2d 273, 276 (5th Cir. 1993); *Stewart v. Bernstein*, 769 F.2d 1088, 1092-93 (5th Cir. 1985); *Estate of Ayres v. Beaver*, 48 F.Supp.2d 1335, 1339-40 (M.D.Fla. 1999); *Nichols v. St. Luke Ctr.*, 800 F.Supp. 1564, 1568 (S.D.Ohio 1992); *Chalfin v. Beverly Enters., Inc.*, 741 F.Supp. 1162, 1170-71 (E.D.Pa. 1989); *Fuzie v. Manor Care, Inc.*, 461 F.Supp. 689, 697 (N.D.Ohio 1977). *But see Roberson V. Wood*, 464 F.Supp. 983, 988-89 (E.D.Ill. 1979). These courts found nothing in the text or legislative

> history of the Medicaid or Medicare Acts before the OBRA '87 amendments to suggest that Congress intended to create a private cause of action.

Brogdon, 103 F.Supp.2d at 1331-32.

Additionally, courts have ruled the *Medicaid* Act does not give rise to an implied right of action. In *Solter v. Health Partners of Philadelphia, Inc.*, 215 F.Supp.2d 533 (E.D.Pa. 2002), after reciting the *Cort* test, the court noted that the Supreme Court "has made clear that the second factor is the most important in determining whether an implied right of action exists. *See Suter v. Artist M.*, 503 U.S. 347, 363, 112 S.Ct. 1360, 118 L.Ed.2d 1 (1992) ('[T]he most important inquiry here ... is whether Congress intended to create the private remedy sought by the plaintiffs.')." *Id.* at 538. "In making this determination, courts must examine the statute's language, structure, and legislative history. *Northwest Airlines, Inc. v. Transport Workers Union*, 451 U.S. 77, 91-94, 101 S.Ct. 1571, 67 L.Ed.2d 750 (1981)." *Id.* (footnote omitted). As to congressional intent, the *Solter* court found "there is no indication in the legislative history of the Medicaid Act that Congress intended to create a private remedy for a private care patient to bring a private action for money damages under the statute. *Steward v. Bernstein*, 769 F.2d 1088, 1093 n.6 (5th Cir. 1985)." Moreover,

> the Medicaid Act actually mandates that the participating states create a voluntary administrative process whereby beneficiaries

> may seek redress for an allegedly wrongful withholding of benefits. . . . This mandate is evidence that Congress anticipated that the states would provide the remedy for vindication of the guidelines and waiver provisions of the Medicaid Act. In other words, there is a remedy available to plaintiffs for the wrong they allege in a state-created forum, rather than in federal court.

Salter, 215 F.Supp.2d at 539.

Because there is no South Carolina authority resolving this question, and only minimal guidance from other jurisdictions, we turn to the United States Supreme Court's prescriptions and doctrinal edifications as to when a private right of action may be implied from a federal statute.

C. Implied Right of Action

During the early era of American jurisprudence, courts addressed the propriety of implying a private cause of action from a federal statute with the maxim, "For every wrong there is a remedy." *See* Susan J. Stabile, *The Role of Congressional Intent in Determining the Existence of Implied Private Rights of Action*, 71 Notre Dame L. Rev. 861, 864 (1996) ("The early view of the courts on the question of when it is appropriate to imply a private cause of action from a federal statute that itself does not provide for such an action was that an individual is entitled to an adequate remedy for any legal wrong, whether common law wrong or statutory wrong.") "Since there was

a remedy for all wrongs, if Congress did not provide for that remedy, the courts should and did." *Id.* However, towards the end of the nineteenth century, the paradigmatic tide began to shift as congressional intent increasingly began to inform courts' implied right of action analyses. *See id.*, citing *Johnson v. S. Pac. Co.*, 196 U.S. 1 (1904). With the New Deal and the efflux of federal legislation that followed came a "more restrictive notion of when to imply private causes of action from federal statutes." *Id.* at 865.

For example, in 1916, the Supreme Court, in *Texas & Pacific Railway v. Rigsby*, 241 U.S. 33 (1916), had implied a private cause of action under the "safety appliance acts." The Court observed that "[n]one of the acts, indeed, contains express language conferring a right of action for the death or injury of an employee; but the safety of employees and travelers is their principal object, and the right of private action by an injured employee, even without the employers' liability act, has never been doubted." 241 U.S. at 39 (citations omitted). Continuing, the Court explained:

> A disregard of the command of the statute is a wrongful act, and where it results in damage to one of the class for whose especial benefit the statute was enacted, the right to recover the damages from the party in default is implied, according to a doctrine of the common law expressed in 1 Comyn's Dig. title, 'Action upon Statute' (F), in these words: 'So, in every case, where a statute enacts or prohibits a thing for the benefit of a person,

> he shall have a remedy upon the same statute for the thing enacted for his advantage, or for the recompense of a wrong done to him contrary to the said law.'

Id. (citations omitted).

By 1934, the tenor of the Court's voice had changed slightly. In *Moore v. Chesapeake & Ohio Railway Co.*, 291 U.S. 205 (1934), the Court held that the original Federal Safety Appliance Act,

> while prescribing absolute duties, and thus creating correlative rights in favor of injured employees, did not attempt to lay down rules governing actions for enforcing these rights. The original act of 1893 made no provision for suits, except for penalties. That act did impliedly recognize the employee's right of action by providing in section 8 that he should not be deemed to have assumed the risk of injury occasioned by the breach of duty. But the act made no provision as to the place of suit or the time within which it should be brought, or as to the right to recover, or as to those who should be the beneficiaries of recovery, in case of the death of the employee.

Id. at 215. Thus, the Moore Court "held that the adjudicatory consequences of the Federal Safety Appliance Act were limited to those expressly provided by Congress." 71 Notre Dame L. Rev. at 865.

> Moore was followed by the Supreme Court's decision in Erie Railroad v. Tompkins, which, although not itself an implication case, rejected the ability of federal courts to create federal common law in diversity cases. . . . In the wake of Erie, federal courts appeared less willing to borrow state law negligence concepts to justify implying causes of action from federal statutes.
>
> Following Erie, the Supreme Court frequently denied private rights of action. In doing so, the Court focused upon the availability of other means to enforce the statutory duty at issue. . . .
>
> Still, in the period prior to 1975, courts did create implied rights of actions when they were thought to be necessary to grant a plaintiff some remedy.

Id. at 866-67 (footnotes omitted).

The year 1975 brought the Supreme Court's ruling in *Cort v. Ash*, 422 U.S. 66 (1975). There, the Court delineated a four-factor test:

> In determining whether a private remedy is implicit in a statute not expressly providing one, several factors are relevant. First, is the plaintiff 'one of the class for whose especial benefit the statute was enacted,' – that is, does the statute create a federal right in favor of the plaintiff? Second, is there any indication of legislative intent, explicit or implicit, either to create such a

> remedy or to deny one? Third, is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff? And finally, is the cause of action one traditionally relegated to state law, in an area basically the concern of the States, so that it would be inappropriate to infer a cause of action based solely on federal law?

422 U.S. at 78 (citations omitted). However, *Cort*'s "new method of analyzing implication questions," soon gave way to "an exclusive reliance on legislative intent." 71 Notre Dame L. Rev. at 867-68.

> The movement started in Cannon v. University of Chicago, in which the Court held that there was a private right of action under section 901 of Title IX of the Education Amendments of 1972. Although the Court analyzed each of the four Cort factors, it expressly viewed the four factors as the means thorough which congressional intent could be discerned.

Id. at 868. *See also Rogers v. Frito-Lay, Inc.*, 611 F.2d 1074, 1088 (5th Cir. 1980) (Goldberg, J., dissenting) ("Only a cave dweller . . . would not realize that there has been a remarkable change of attitude by the Supreme Court regarding the inference of private rights of action in the last fifteen years.") (quoted in *Home Health Services, Inc. v. Currie*, 531 F.Supp. 476 (D.S.C. 1982)).

The manner by which the Court currently determines whether an implicit private cause of action is created by a federal statute is exemplified by *Touche Ross & Co. v. Redington*, 442 U.S. 560 (1979):

> The question of the existence of a statutory cause of action is, of course, one of statutory construction. *Cannon v. University of Chicago*, 441 U.S. 677, 688, 99 S.Ct. 1946, 1953, 60 L.Ed.2d 560 (1979); *see National Railroad Passenger Corp. v. National Association of Railroad Passengers*, 414 U.S. 453, 458, 94 S.Ct. 690, 693, 38 L.Ed.2d 646 (1974) (hereinafter *Amtrak*). SIPC's argument in favor of implication of a private right of action based on tort principles, therefore, is entirely misplaced. Brief for Respondent SIPC 22-23. As we recently have emphasized, "the fact that a federal statute has been violated and some person harmed does not automatically give rise to a private cause of action in favor of that person." *Cannon v. University of Chicago, supra*, 441 U.S., at 688, 99 S.Ct., at 1953. Instead, ***our task is limited solely to determining whether Congress intended to create the private right of action***. . . .

442 U.S. at 568 (emphasis added). The Court has further elucidated:

> In determining whether a federal statute that does not expressly provide for a particular private right of action nonetheless implicitly created that right, our task is one of statutory construction. *See Touche Ross & Co. v. Redington*, 442 U.S. 560, 568, 99 S.Ct.

> 2479, 2485, 61 L.Ed.2d 82. The ultimate question in cases such as this is whether Congress intended to create the private remedy – for example, a right to contribution – that the plaintiff seeks to invoke. *See Transamerica Mortgage Advisors, Inc. v. Lewis*, 444 U.S. 11, 15-16, 100 S.Ct. 242, 245, 62 L.Ed.2d 146; *Universities Research Assn., Inc., supra*, at 770, 101 S.Ct., at 1461. Factors relevant to this inquiry are the language of the statute itself, its legislative history, the underlying purpose and structure of the statutory scheme, and the likelihood that Congress intended to supersede or to supplement existing state remedies.

Northwest Airlines, Inc. v. Transport Workers Union of America, AFL-CIO, 451 U.S. 77, 91 (1981).

The Supreme Court's opinion in *Alexander v. Sandoval*, 532 U.S. 275 (2001) is particularly instructive:

> Like substantive federal law itself, private rights of action to enforce federal law must be created by Congress. *Touche Ross & Co. v. Redington*, 442 U.S. 560, 578, 99 S.Ct. 2479, 61 L.Ed.2d 82 (1979) (remedies available are those "that Congress enacted into law"). The judicial task is to interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy. *Transamerica Mortgage Advisors, Inc. v. Lewis*, 444 U.S. 11, 15, 100 S.Ct. 242, 62 L.Ed.2d

146 (1979). Statutory intent on this latter point is determinative. *See, e.g., Virginia Bankshares, Inc. v. Sandberg*, 501 U.S. 1083, 1102, 111 S.Ct. 2749, 115 L.Ed.2d 929 (1991); *Merrell Dow Pharmaceuticals Inc. v. Thompson*, 478 U.S. 804, 812, n. 9; 106 S.Ct. 3229, 92 L.Ed.2d 650 (1986) (collecting cases). Without it, a cause of action does not exist and courts may not create one, no matter how desirable that might be as a policy matter, or how compatible with the statute. *See, e.g., Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 145, 148, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985); *Transamerica Mortgage Advisors, Inc. v. Lewis, supra*, at 23, 100 S.Ct. 242; *Touche Ross & Co. v. Redington, supra*, at 575-576, 99 S.Ct. 2479. "Raising up causes of action where a statute has not created them may be a proper function for common-law courts, but not for federal tribunals." *Lampf, Pleva, Lipkind, Prupis & Petigrow v. Gilbertson*, 501 U.S. 350, 365, 111 S.Ct. 2773, 115 L.Ed.2d 321 (1991) (SCALIA, J., concurring in part and concurring in judgment).

Respondents would have us revert in this case to the understanding of private causes of action that held sway 40 years ago when Title VI was enacted. That understanding is captured by the Court's statement in J.I. *Case Co. v. Borak*, 377 U.S. 426, 433, 84 S.Ct. 1555, 12 L.Ed.2d 423 (1964), that "it is the duty of the courts to be alert to provide such remedies as are necessary to make effective the congressional purpose" expressed

> by a statute. We abandoned that understanding in *Cort v. Ash,* 422 U.S. 66, 78, 95 S.Ct. 2080, 45 L.Ed.2d 26 (1975) – which itself interpreted a statute enacted under the *ancien regime* – and have not returned to it since. Not even when interpreting the same Securities Exchange Act of 1934 that was at issue in *Borak* have we applied *Borak's* method for discerning and defining causes of action. *See Central Bank of Denver, N.A. v. First Interstate Bank of Denver, N. A., supra,* at 188, 114 S.Ct. 1439; *Musick, Peeler & Garrett v. Employers Ins. of Wausau,* 508 U.S. 286, 291-293, 113 S.Ct. 2085, 124 L.Ed.2d 194 (1993); *Virginia Bankshares, Inc. v. Sandberg, supra,* at 1102-1103, 111 S.Ct. 2749; *Touche Ross & Co. v. Redington, supra,* at 576-578, 99 S.Ct. 2479. Having sworn off the habit of venturing beyond Congress's intent, we will not accept respondents' invitation to have one last drink.

532 U.S. at 286-87.

D. Application

Adverting our discussion from the historical evolvement of the implied right of action doctrine to the case *sub judice,* we find nothing in the language of the statute to indicate Congress intended an implicit right to file a private cause of action against a physician for failing to file a Medicare claim. As the United States Supreme Court stated in *Northwest Airlines*:

> "A frequently stated principle of statutory construction is that when legislation expressly provides a particular remedy or remedies, courts should not expand the coverage of the statute to subsume other remedies." *National Railroad Passenger Corp. v. National Association of Railroad Passengers,* 414 U.S. 453, 458, 94 S.Ct. 690, 693, 38 L.Ed.2d 646.

451 U.S. at 94 n.30.

The Medicare Act provides for specific remedies in the form of sanctions and penalties, and this weighs against finding that Congress intended to create the remedy of a private right of action. Unless congressional intent can be "inferred from the language of the statute, the statutory structure, or some other source, the essential predicate for implication of a private remedy simply does not exist." *Id.* at 94. Here, we are unable to discover any manifestation of intent on the part of Congress to create a right to bring a private action against the physicians for failing to properly file a Medicare claim pursuant to 42 U.S.C.A. § 1395w-4(g)(4).

II. Negligence

We find the trial court properly granted summary judgment on the portion of the negligence cause of action based upon the Doctors' failures to file Medicare claims.

A. Failure to File

Mrs. Wogan contends the Doctors are liable for damages:

> In negligently and recklessly failing to address the constant pleas from the Decedent and the Plaintiff for help in submitting a Medicare claim;
>
> In negligently and recklessly failing to submit a Medicare claim on or about May 25, 2001, on or about June 22, 2001, on or about July 20, 2001, on or about August 24, 2001, and thereafter. . . .

Both of these claims arise specifically from the failure of the Doctors to follow the provision of 42 U.S.C.A. § 1395w-4(g)(4)(A) requiring them to submit a claim. Ms. Wogan relies on affidavits as well as guidelines, which refer to the Medicare Act and its requirement that physicians file claims. Essentially, Ms. Wogan is asserting an action for violation of the Medicare Act under the rubric of a state law claim. Accordingly, the trial court properly granted summary judgment to the Doctors on Ms. Wogan's cause of action for negligence based on the Doctors' failures to file a Medicare claim.

Ms. Wogan alternatively maintains the violations of the statute are either evidence of negligence per se, or "indicia of negligence" that should be considered in a broader scope than just as a violation of the Medicare Act. We disagree.

B. Negligence Per Se

Negligence per se is negligence arising from a defendant's violation of a statute. *Trivelas v. South Carolina Dep't of Transp.*, 348 S.C. 125, 134, 558 S.E.2d 271, 275 (Ct. App. 2001). In *Rayfield v. South Carolina Department of Corrections*, 297 S.C. 95, 374 S.E.2d 910 (Ct. App. 1988), we enunciated the test for determining when a duty created by statute will support an action for negligence:

> In order to show that the defendant owes him a duty of care arising from a statute, the plaintiff must show two things: (1) that the essential purpose of the statute is to protect from the kind of harm the plaintiff has suffered; and (2) that he is a member of the class of persons the statute is intended to protect.
>
> If the plaintiff makes this showing, he has proven the first element of a claim for negligence: viz., that the defendant owes him a duty of care. If he then shows that the defendant violated the statute, he has proven the second element of a negligence cause of action: viz., that the defendant, by act or omission, failed to exercise due care. This constitutes proof of negligence *per se*.

Id. at 103, 374 S.E.2d at 914-15 (footnote omitted). "In a subsequent decision, our Supreme Court further extended the analysis by stating that 'the plaintiff must prove violation of the statute was causally linked, both in fact and proximately, to the injury.'"

Hurst v. Sandy, 329 S.C. 471, 478, 494 S.E.2d 847, 850 (Ct. App. 1997) (quoting *Whitlaw v. Kroger Co.*, 306 S.C. 51, 55, 410 S.E.2d 251, 253 (1991)).

In the instant case, the Medicare Act was not created to protect from a harm, but instead to create "a voluntary insurance program to provide medical insurance benefits in accordance with the provisions of this part for aged and disabled individuals who elect to enroll under such program[.]" 42 U.S.C.A. § 1395j. While section 1395w-4(g) provides a requirement for the filing of a Medicare claim, it was not designed to protect from a harm. It is an administrative section designed to maintain the orderly operation and handling of the program. Accordingly, we reject the claim that the references to the Medicare Act provide a basis for a negligence per se claim.

C. Indicia of Negligence

Finally, Ms. Wogan's argument that the references are only "indicia of negligence" does not satisfy the requirements of a negligence claim. A party must show a duty that was breached. *See Willis v. Wu*, 362 S.C. 146, 154, 607 S.E.2d 63, 67 (2004) (finding plaintiff in a medical malpractice action must show duty on the part of the physician); *Doe v. Marion*, 361 S.C. 463, 470, 605 S.E.2d 556, 560 (Ct. App. 2004) ("In order to prove negligence, the plaintiff must show: (1) defendant owes a duty of care to the plaintiff; (2) defendant breached the duty by a negligent act or omission; (3) defendant's breach was the actual

and proximate cause of the plaintiff's injury; and (4) plaintiff suffered an injury or damages."); *Andrade v. Johnson*, 356 S.C. 238, 245, 588 S.E.2d 588, 592 (2003) (same); *Regions Bank v. Schmauch*, 354 S.C. 648, 668, 582 S.E.2d 432, 443 (Ct. App. 2003) (same). There is no duty to either Mr. or Ms. Wogan unless an implicit right of action exists under the Medicare Act. Therefore, we find the trial court properly granted summary judgment to the Doctors on Ms. Wogan's claims of negligence based on the failure to file a Medicare claim.

III. Breach of Third-Party Beneficiary Contract

Ms. Wogan contends the trial court erred in granting summary judgment to the Doctors on her claim they breached their contract to provide Medicare-covered services. She maintains Mr. Wogan was a third-party beneficiary of the contract, and their failure to submit the claim renders them liable for breach. We disagree.

> Generally, a third person not in privity of contract with the contracting parties has no right to enforce a contract. However, when the contract is made for the benefit of the third person, that person may enforce the contract if the contracting parties intended to create a direct, rather than an incidental or consequential, benefit to such third person.

Goode v. St. Stephens United Methodist Church, 329 S.C. 433, 445, 494 S.E.2d 827, 833 (Ct. App. 1997) (citing *Bob Hammond Constr. Co. v. Banks Constr. Co.*, 312 S.C. 422, 440 S.E.2d 890 (Ct. App. 1994)).

The only contract appearing in the record is the Medicare Participating Physician/Supplier Agreement. It states:

> The above-named person or organization [Dr. Kunze], called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

This document defines assignment, sets forth the effective date of the contract, and establishes the terms for termination of the agreement. The contract contains no provisions specifically detailing the requirement to submit a claim or any liability resulting from the physician's failure to file.

Nothing in the contract creates liability outside the Medicare Act. Because the Act does not confer a private right of action to sue a physician for failing to submit a claim, we refuse to allow an action against a physician on the ground he breached his contract to provide services outlined in the Medicare Act.

IV. Breach of Fiduciary Duty

Ms. Wogan argues the trial court erred in finding her claims that the Doctors breached their fiduciary duties were mere restatements of her claims for medical negligence. We disagree.

A fiduciary relationship is founded on the trust and confidence reposed by one person in the integrity and fidelity of another. *Ellis v. Davidson*, 358 S.C. 509, 519, 595 S.E.2d 817, 822 (Ct. App. 2004); *Regions Bank v. Schmauch*, 354 S.C. 648, 670, 582 S.E.2d 432, 444 (Ct. App. 2003); *Redwend Ltd. P'ship v. Edwards*, 354 S.C. 459, 476, 581 S.E.2d 496, 505 (Ct. App. 2003), *cert. denied* (Mar. 18, 2004). A fiduciary relationship exists when one imposes a special confidence in another, so that the latter, in equity and good conscience, is bound to act in good faith and with due regard to the interests of the one imposing the confidence. *Hendricks v. Clemson Univ.*, 353 S.C. 449, 458, 578 S.E.2d 711, 715 (2003).

South Carolina has recognized the doctor-patient relationship as a confidential relationship. *McCormick v. England*, 328 S.C. 627, 639, 494 S.E.2d 431, 437 (Ct. App. 1997); *see also Hodge v. Shea*, 252 S.C. 601, 608, 168 S.E.2d 82, 85 (1969). However, this state has not found that medical negligence or malpractice will support a cause of action for breach of fiduciary duty. Nor have our courts found the failure of a doctor to offer assistance in filing a Medicare claim or other claim is a breach of fiduciary duty.

In *McCormick*, this Court found actionable a doctor's breach of the duty to maintain the confidences of his or her patient where no compelling public interest or other justification for the disclosure exists. *McCormick*, 328 S.C. at 640, 494 S.E.2d at 437. In *Hodge*, the court found a doctor owed a duty not to use undue influence in a sale of land over a patient with decreased mental capacity as a result of age and disease. *Hodge*, 252 S.C. at 608-09, 168 S.E.2d at 85.

In the action *sub judice*, Ms. Wogan's complaint asserted the cause of action for breach of fiduciary duty was based upon the Doctors' "fiduciary duty to provide appropriate medical treatment and care . . . in his time of need and in a prompt, efficient, proper, professional, ethical, competent and appropriate manner." The complaint alleges the Doctors had duties to:

> a. Promptly purchase the Sandostatin LAR while the Decedent, JAMES JOHN WOGAN, remained under their continuous care and treatment and then promptly submit a Medicare claim, failure to do so constitutes abandonment; or
>
> b. Promptly require the Decedent, JAMES JOHN WOGAN, to sign an Advanced Beneficiary Notice, promptly purchase the Sandostatin LAR Depot and then promptly submit a Medicare claim, failure to do so constitutes abandonment; or

c. Provide the injection via an outpatient procedure; or

d. Answer the pleas from the Decedent and/or the Plaintiff for assistance in alternative means of financing a Thirty Thousand ($30,000.00) Dollar a year medication; or

e. Other duties.

These allegations are restatements of the basic charges raised in the medical negligence or malpractice cause of action in the complaint. We find the assertions do not rise to the level of a breach of fiduciary duty on the part of the Doctors. To hold the Doctors liable for failure to file the Medicare claim would render meaningless our ruling that there is no private right of action arising under the Medicare Act. Accordingly, we hold the trial court properly granted summary judgment to the Doctors on Ms. Wogan's cause of action for breach of fiduciary duty.

V. Unfair Trade Practices

Ms. Wogan asseverates the court improperly granted summary judgment to Dr. Kunze on the cause of action for violation of the Unfair Trade Practices Act, section 39-5-140 of the South Carolina Code (Supp. 2004). We disagree.

"An unfair trade practice has been defined as a practice which is offensive to public policy or which is immoral, unethical, or oppressive." *deBondt v. Carlton Motorcars, Inc.*, 342 S.C. 254, 269, 536 S.E.2d

399, 407 (Ct. App. 2000) (citation omitted). "Even a truthful statement may be deceptive if it is has a capacity or tendency to deceive." *Id.* (internal quotation marks and citation omitted). To be actionable under the UTPA, the unfair or deceptive act or practice must have an impact upon the public interest. *Id.* (citing *Haley Nursery Co. v. Forrest*, 298 S.C. 520, 381 S.E.2d 906 (1989)). "An impact on the public interest may be shown if the acts or practices have the potential for repetition." *Singleton v. Stokes Motors, Inc.*, 358 S.C. 369, 379, 595 S.E.2d 461, 466 (2004) (citing *Crary v. Djebelli*, 329 S.C. 385, 387, 496 S.E.2d 21, 23 (1998)).

> The potential for repetition may be shown in either of two ways:
>
> (1) by showing the same kind of actions occurred in the past, thus making it likely they will continue to occur absent deterrence; or
>
> (2) by showing the company's procedures created a potential for repetition of the unfair and deceptive acts.

Id.

Section 39-5-140 states:

> Any person who suffers any *ascertainable loss* of money or property, real or personal, as a result of the use or employment by another person of an unfair or deceptive method, act or practice declared unlawful by § 39-5-20 may bring an action individually, *but not in a representative capacity*, to

> recover actual damages. If the court finds that the use or employment of the unfair or deceptive method, act or practice was a willful or knowing violation of § 39-5-20, the court shall award three times the actual damages sustained and may provide such other relief as it deems necessary or proper. Upon the finding by the court of a violation of this article, the court shall award to the person bringing such action under this section reasonable attorney's fees and costs.

S.C. Code Ann. § 39-5-140(a) (Supp. 2004) (emphasis added).

The trial court granted summary judgment in favor of the Doctors because it found (1) Ms. Wogan brought the action in her representative capacity as the personal representative of her husband's estate; and (2) she, in her individual capacity, did not show evidence of an ascertainable loss suffered.

A. Preservation

First, Ms. Wogan argues the trial court improperly based its grant of summary judgment on a ground not raised by the Doctors. This issue is not properly preserved. While Ms. Wogan noted in her motion to alter or amend pursuant to Rule 59, SCRCP, that the court *sua sponte* made findings of fact regarding the claim, she presented no argument or authority to show this was error. Thus, the issue was not properly presented to the trial court. *See In re Estate of Timmerman*, 331 S.C. 455, 460, 502

S.E.2d 920, 923 (Ct. App. 1998) (holding if a trial judge grants "relief not previously contemplated or presented to the trial court, the aggrieved party must move, pursuant to Rule 59(e), SCRCP, to alter or amend the judgment in order to preserve the issue for appeal").

B. Theory of Recovery

At the summary judgment motion hearing, Ms. Wogan's counsel argued the basis for the claim was Dr. Kunze's continued billing of Mr. Wogan for the injections of Sandostatin LAR. Her counsel specifically stated the cause of action was supported without any reference to the Medicare Act. The bill was sent to Mr. Wogan and was based upon services rendered to him. Ms. Wogan never claimed an individual loss as a result of the "inaccurate, deceptive bill."

Ms. Wogan now maintains she suffered an ascertainable loss because she paid for the Sandostatin LAR at the pharmacy. However, payment of the drug did not form the basis of the argument she presented at the summary judgment hearing, and Ms. Wogan cannot now change her theory of recovery. *See Easterlin v. Green*, 248 S.C. 389, 395, 150 S.E.2d 473, 476 (1966) (finding a party may not argue one theory before the trial court and another on appeal); *see also Crawford v. Henderson*, 356 S.C. 389, 409, 589 S.E.2d 204, 215 (Ct. App. 2003) (citing *Wilder Corp. v. Wilke*, 330 S.C. 71, 76, 497 S.E.2d 731, 733 (1998) ("It is

axiomatic that an issue cannot be raised for the first time on appeal, but must have been raised to and ruled upon by the trial judge to be preserved for appellate review."); *State v. Bailey*, 298 S.C. 1, 5-6, 377 S.E.2d 581, 584 (1989) (stating a party may not argue one ground at trial and then an alternative ground on appeal)).

C. Ascertainable Loss

Nevertheless, Ms. Wogan's Unfair Trade Practices Act claim is unprevailing on the merits.

> Under S.C. Code Ann. § 39-5-140(a) (1985), any person who suffers any ascertainable loss of money or property, real or personal, as a result of the use or employment by another person of an unfair or deceptive method, act or practice declared unlawful by § 39-5-20 may bring an action individually, but not in a representative capacity, to recover actual damages.

Reynolds v. Ryland Group, Inc., 340 S.C. 331, 333, 531 S.E.2d 917, 918-19 (2000).

We are constrained to analyze the Unfair Trade Practices Act claim with reference to Ms. Wogan's original contention that the unfair trade practice was Dr. Kunze's billing for the administration of the Sandostatin LAR. There is no evidence in the record that Ms. Wogan paid this bill for $11.76. Furthermore, the medical services at issue here were

rendered to Mr. Wogan. She has not demonstrated an ascertainable loss based on the alleged unfair billing.

D. Representative Capacity

Finally, an unfair trade practices claim may not be brought in a representative capacity. S.C. Code Ann. § 39-5-140(a) (Supp. 2004) ("Any person who suffers any ascertainable loss of money . . . as a result of the use or employment by another person of an unfair or deceptive method, act or practice declared unlawful by § 39-5-20 may bring an action individually, *but not in a representative capacity*, to recover actual damages.") (emphasis added). Losses incurred by Mr. Wogan are inapposite here because Ms. Wogan is not permitted to assert a claim on his behalf. Because she did not demonstrate an ascertainable loss, and an action for losses incurred by Mr. Wogan cannot be maintained, we find the trial court properly granted summary judgment.

VI. Dr. Thomas

Ms. Wogan contends the trial court improperly granted summary judgment to Dr. Thomas on the ground he never prescribed the medication. We disagree.

In order to support a cause of action for negligence, the plaintiff must prove the existence of a duty. *See Sabb v. South Carolina State Univ.*, 350 S.C. 416, 429, 567 S.E.2d 231, 237 (2002); *Steinke v. South*

Carolina Dep't of Labor, Licensing and Regulation, 336 S.C. 373, 387, 520 S.E.2d 142, 149 (1999). "Generally, there is no common law duty to act . . . Thus, a person usually incurs no liability when he fails to take steps to protect others from harm not created by his own wrongful conduct." *Dennis by Evans v. Timmons*, 313 S.C. 338, 342, 437 S.E.2d 138, 141 (Ct. App. 1993).

We find the court properly granted summary judgment to Dr. Thomas and Gary W. Thomas, M.D., P.A., because Dr. Thomas never prescribed the medication Sandostatin LAR and had no duty to file a claim with Medicare, or to help Ms. Wogan file a claim with Medicare. Indubitably, Dr. Thomas has no duty to file a Medicare claim for medicine he has not prescribed. Accordingly, we rule the trial court properly granted summary judgment to Dr. Thomas and Gary W. Thomas, M.D., P.A. due to the inability of Ms. Wogan to demonstrate they owed her or her husband a duty.

CONCLUSION

We hold there is no private right of action created, either expressly or implicitly, by the Medicare Act. The trial court properly granted summary judgment to the Doctors on Ms. Wogan's claim for negligence arising from their failures to file Medicare claims and on her claim for breach of third-party beneficiary contract because the claims were an attempt to create a private cause of action where

none exists. We find the court properly granted summary judgment on Ms. Wogan's claim for unfair trade practices. Finally, we rule the court did not err in granting Dr. Thomas and his practice summary judgment on the ground Ms. Wogan failed to prove they owed her or her husband a duty to file a claim or to assist her in filing a claim for medicine he did not prescribe. The decision of the trial court is

AFFIRMED.

HUFF and WILLIAMS, JJ., concur.

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF BEAUFORT	)	CIVIL ACTION NUMBER 02-CP-07-1709

PHYLLIS J. WOGAN, individually and as Personal Representative of the ESTATE OF JAMES J. WOGAN,

Plaintiffs,

vs.

KENNETH C. KUNZE, M. D.; HILTON HEAD GASTROENTEROLOGY, P. A.; THOMAS P. RZECYCKI, M. D.; HILTON HEAD GENERAL AND LAPAROSCOPIC SURGERY, P. A.; GARY W. THOMAS, M. D.; and GARY W. THOMAS M. D., P.A.,

Defendants.

ORDER

(Filed Jul. 6, 2004)

This case is before the undersigned on Motions filed by the Parties herein, as follows:

1. The Motion for Summary Judgment of the Defendants Kenneth C. Kunze and Hilton Head Gastroenterology, P. A. (hereinafter, "Kunze"), filed on February 18, 2004;

2. The Motion for Summary Judgment of Gary W. Thomas, M. D., and Gary W. Thomas, M. D., P. A. (hereinafter, "Thomas"), filed on April 15, 2004; and,

3. The Plaintiffs' Motion to Compel, filed on June 14, 2004.

The Motions came to be heard on June 28, 2004, at 11:00 o'clock, A. M., at the Beaufort County Court House. Present were Timothy M. Wogan, Isaac M. Stone, III, and Marshall J. Waldron, attorneys for the Plaintiffs; James S. Gibson, Jr., and Mary B. Lohr, attorneys for Kunze; and, Elliott T. Halio, attorney for Thomas.

1. Plaintiffs' Motion to Compel: The Plaintiffs' Motion to Compel seeks and Order compelling Kunze to answer the Plaintiffs' Second Set of Interrogatories, served on or about December 8, 2003. Kunze advised that the answers would be provided on or before July 11, 2004. Accordingly, the Plaintiffs' Motion to Compel is granted, and Kunze shall file and serve their answers to the Plaintiffs' Second Set of Interrogatories, served on or about December 8, 2003, on or before July 11, 2004.

2. Defendants' Motions for Summary Judgment: This is a medical negligence case. In a detailed Amended Complaint, the Plaintiffs allege that the Defendants herein were negligent in numerous particulars relating to the care of James J. Wogan in the final months of his life.[1]

In addition to the causes of action alleging medical negligence by the Defendants in the treatment

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[1] *See:* Amended Complaint dated, February 16, 2004.

and care of James J. Wogan, the Plaintiffs also allege certain causes of action against in connection with the Defendants' alleged mis-handling of, or failure to file, Medicare claims on behalf of James J. Wogan.[2] These causes of action are styled as "Breach of Third Party Beneficiary Contract"; "Unfair and Deceptive Trade Practices", and "Breach of Fiduciary Duty".

(a) Motion for Summary Judgment of the Defendants Kenneth C. Kunze and Hilton Head Gastroenterology, P. A.:

In the Motion for Summary Judgment, Kunze sought summary judgment as to the following claims asserted by the Plaintiffs:

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[2] These claims arise as a result of the actions of Kunze in prescribing a drug known as Sandostatin LAR to James J. Wogan. In the final months of his life, Mr. Wogan was suffering from debilitating bouts of diarrhea, and the Sandostatin LAR controlled the condition. Sandostatin LAR is very expensive, costing in excess of Two Thousand Seven Hundred Dollars per dose which is administered once a month. The evidence that is of record shows that Kunze would not submit claims for the drug to Medicare, because he did not believe it was covered by Medicare in this situation. The Plaintiffs requested that Thomas file a claim with Medicare for the Sandostatin LAR, and he would not because he did not prescribe it. The Plaintiffs also requested that Thomas write a prescription for the Sandostatin LAR himself and file the claim for it with Medicare, and he would not because the treatment was being provided by Kunze.

(i) Negligence in refusing to submit a Medicare claim for certain medication prescribed by Kunze;[3]

(ii) Breach of Third Party Beneficiary Contract;

(iii) A violation of the South Carolina Unfair Trade Practices Act for the actions of Kunze in connection with the failure of the Defendants to submit a Medicare claim for certain medication prescribed by Kunze; and,

(iv) A breach of fiduciary duty in connection with the actions of Kunze in connection with the failure of the Defendants to submit a Medicare claim for certain medication prescribed by Kunze.[4]

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[3] The alleged negligence of the Defendants with respect to the Medicare issues are not set forth as a separate cause of action, but are set out as specifications of negligence in the negligence cause of action. *See:* Amended Complaint, paragraph 89, (n)(o)(xx) and (yy).

[4] Initially, the Plaintiffs argued that all of the Defendants' Motions for Summary Judgment failed to comply with the requirements of Rule 7(b), S. C. R. C. P., because the Defendants failed to state the grounds upon which the Motions were based in the text thereof. The Defendants did state the grounds with particularity in the memoranda filed at the time of the argument of the Motions. I was unwilling to dismiss the Motions for this reason, but I was willing to postpone the hearing on the Motion in order to allow the Plaintiffs such time as they deemed necessary in order to respond to the grounds as stated in the memoranda filed by the Defendants. The Plaintiffs then stated that they were prepared to move forward and argue on the grounds as stated by the Defendants in the memoranda, and

(Continued on following page)

Negligence and Breach of Third Party Beneficiary Contract: Kunze argues that the Medicare Act [42 U.S.C. § 1395(a), *et seq.*] provides no private right of action for the alleged violations thereof. The Plaintiffs concede that there is no express cause of action provided in the Medicare Act, but argue that an implied right of action should be recognized, citing the case of *Currie v. Home Health Services, Inc., et al.*, 706 F. 2d 497 [C.A. 4,(S.C.) 1983). *Currie, supra.*, confirms that there is no express private right of action created by the Medicare Act, and holds that there is no implied right of action for an accredited provider of services under the Medicare Act. Thus, the issue decided in *Currie, supra.*, does not answer the question of whether or not a patient has a private cause of action under the Medicare Act.

At the argument, the Plaintiff cited *Currie, supra.*, but was actually relying on language that appears in the trial court's decision rendered in *Home Health Services, Inc. v. Currie*, 531 F.Supp. 476 (D.C.S.C. 1982). The final line in *Home Health Services, Inc., supra.*, reads, in relevant part:

> . . . This court expresses no opinion on the question of whether a private cause of action

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that they did not require additional time to be adequately prepared to meet the Motions.

> in favor of Medicare recipients themselves could be implied under 42 U.S.C. § 1392(a).[5]

In determining whether to infer a private cause of action from a federal statute, it has been held that the focal point is Congress' intent enacting the statute. The United States Supreme Court set out guides to discerning that intent in the case of *Cort v. Ash*, 422 U.S. 66, 78, 95 S.Ct. 2080, 2088, 45 L.Ed.2d 26 (1975). In subsequent decisions, the United States Supreme Court held that the intent of Congress remains the ultimate issue, however, the other factors in the *Cort, supra.*, decision notwithstanding. The United States Supreme Court went further and held:

> " . . . unless this congressional intent can be inferred from the language of the statute, the statutory structure, or some other source, the essential predicate for implication of a private remedy simply does not exist."

See: Northwest Airlines Inc. v. Transport Workers, 451 U.S. 77, 94, 101 S.Ct. 1571, 1582, 67 L.Ed.2d 750

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[5] In the twenty one years that have passed since *Home Health Services, Inc., supra.*, and *Currie, supra.*, were handed down, it does not appear that any court has risen to the bait and decided whether or not an implied right of action exists in favor of patients under the Medicare Act. There have been decisions holding that no implied right of action exists under the Medicaid Act. For example: there is no implied right of action under the Medicaid Act for nursing home residents to sue for involuntary discharges from nursing homes *Stewart v. Bernstein*, 769 F.2d 1088 (5th Cir.1985); *Estate of Ayers ex rel. Strugnell v. Beaver*, 48 F.Supp.2d 1335 1340-41 (M.D.Fla. 1999).

(1981). In this case, the Plaintiffs have not pointed to any language, within the Medicare Act that would support the argument that the United States Congress intended to create an implied cause of action.

Accordingly, because it does not appear that an express or implied cause of action exists for either negligence or breach of contract under the Medicare Act, summary Judgment as to these claims is proper.

Unfair Trade Practices: The Unfair Trade Practices claims asserted by the Plaintiff Phyllis J. Wogan individually, and as Personal Representative of the Estate of James J. Wogan, fail as a matter of law. S. C. Code Ann. § 39-5-140 (Supp. 2003), reads, in relevant part:

> Any person who suffers any ascertainable loss of money or property, real or personal, as a result of the use or employment by another person of an unfair or deceptive method, act or practice declared unlawful by § 39-5-20 may bring an action individually, *but not in a representative capacity*, to recover actual damages. (emphasis supplied)

In this case, the ascertainable loss of money was that of James J. Wogan. Phyllis J. Wogan can neither assert the claim in a representative capacity, or piggyback her claim onto that of James J. Wogan.[6]

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[6] I recognize, of course, that Mr. and Mrs. Wogan were married, and, presumably, the funds used to pay for the medication came from marital assets. I do not believe that this changes

(Continued on following page)

See also: 28 S.C. Jur. Unfair Trade Practices Act §§ 8; *Faircloth v. Jackie Fine Arts, Inc.*, 682 F.Supp. 837 (1988), *reversed in part*, 938 F.2d 513 (1988); *Omni Outdoor Advertising, Inc. v. Columbia Outdoor Advertising, Inc.*, 974 F.2d 502 [C.A. 4, (S.C.) 1992].[7]

Breach of Fiduciary Duty: In their Fourth Cause of Action, the Plaintiffs allege that the relationship between James J. Wogan and Kunze was a fiduciary relationship. Indeed, the relationship between a doctor and his patient has been described as a fiduciary relationship.[8] The allegations of the Fourth Cause of Action, however, do not point to the existence of a violation of the fiduciary relationship (such as in the unauthorized publication of patient confidences), but rather are a restatement of the claims of medical negligence set forth elsewhere in the complaint. The

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the result, though. James J. Wogan was the individual to whom the services either were, or were not, as the case may be, provided. Thus the wrong, if any, and the damage arising from it, belonged to him.

[7] One other fact was alleged by the Plaintiff to create a violation of the South Carolina Unfair Trade Practices Act against Kunze. That was the fact that these Defendants sent bills to the Plaintiffs, both prior to and after the passing of James J. Wogan for services rendered that had been covered by Medicare. The bill was in the amount of Eleven and 76/100 ($11.76) Dollars. There was no evidence that this bill was ever paid by the Plaintiffs, though, and thus the requirement of S. C. Code Ann. § 39-5-140 (Supp. 2003), for an "ascertainable loss of money" is not met by this state of facts.

[8] *See: McCormick v. England*, 328 S.C. 627, 494 S.E.2d 431 (S.C.App. 1998).

Plaintiffs point to no authority for the proposition that an act of medical negligence is a breach of the fiduciary duty that may exist between a doctor and a patient.

(b) Motion for Summary Judgment of the Defendants Gary W. Thomas, M. D., and Gary W. Thomas M. D., P. A.:

In the Motion for Summary Judgment, Thomas sought summary judgment for the same claims and, except as set forth below, for the same reasons as the motion filed by Kunze. The conclusions reached above with respect to the motion of Kuntz, also apply to the motion of Thomas, and I adopt them as the findings and conclusions with respect to the motion of Thomas.

The Plaintiffs' allegations of negligence, Breach of Third Party Beneficiary Contract, Breach of Fiduciary Duty and Violation of the South Carolina Unfair Trade Practices Act against Thomas fail for another reason. The only evidence in the record is that the prescription for the Sandostatin LAR that gives rise to these claims was not written by Thomas, but rather was written by Kunze. The Plaintiffs provided no authority for the proposition that a physician has a duty to, or is even authorized to, submit Medicare claims for services that the physician did not provide.[9]

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[9] The gravamen of the Plaintiffs' allegations against Thomas is that when Kunze failed to submit the Medicare claim

(Continued on following page)

Indeed, the Plaintiffs plead and offered testimony that, with respect to the prescription of Sandostatin LAR that Thomas as did, in fact, write or authorize, a claim for it was submitted to Medicare.[10]

CONCLUSION

For the reasons set forth above, It is Ordered:

1. The Defendants Kenneth C. Kunze and Hilton Head Gastroenterology, P. A., shall file and serve their answers to the Plaintiffs' Second Set of Interrogatories, served on or about December 8, 2003, on or before July 11, 2004.

2. The Motion for Summary Judgment of the Defendants Kenneth C. Kunze and Hilton Head Gastroenterology, P.A., is granted, and the Plaintiffs' claim for negligence based on the failure of these Defendants to

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for the prescription, Thomas should have stepped in and submitted a claim for the prescription written by Kunze, or he should have written a prescription himself and submitted the claim. The failure of Thomas to prescribe indicated and necessary medication, if proven, might form the basis of a finding of medical negligence against him. However, since he never wrote a prescription, there was no claim for him to submit. Further, and as was stated above, the Plaintiffs did not demonstrate that a physician has a duty to, or is even authorized to, submit Medicare claims for services that the physician did not provide.

[10] *See:* Amended Complaint, paragraph 77; Affidavit of Phyllis J. Wogan, paragraph 30. During one of James J. Wogan's hospitalizations, Thomas ordered a continuation of all medications that Mr. Wogan was on, which included the Sandostatin LAR.

file a Medicare claim related to the Sandostatin LAR is dismissed, and the Plaintiffs' Second, Third and Fourth Causes of Action are dismissed.

3. The Motion for Summary Judgment of the Defendants Gary W. Thomas, M. D., and Gary W. Thomas, M. D., P. A., is granted, and the Plaintiffs' claim for negligence based on the failure of these Defendants to file a Medicare claim related to the Sandostatin LAR, is dismissed, and the Plaintiffs' Second, Third and Fourth Causes of Action are dismissed.

IT IS SO ORDERED.

/s/ Curtis L. Coltrane
Curtis L. Coltrane, Master
In Equity and Special Circuit
Judge for Beaufort County,
South Carolina

Beaufort, South Carolina

This 5th Day of July, 2004.

[SEAL]

The Supreme Court of South Carolina

DANIEL E. SHEAROUSE
CLERK OF COURT

BRENDA F. SHEALY
CHIEF DEPUTY CLERK

POST OFFICE BOX 11330
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SOUTH CAROLINA 29211

(803) 734-1080

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October 9, 2008

Samuel S. Svalina, Esquire
P. O. Drawer 1207
Beaufort, SC 29901-1207

Timothy M. Wogan, Esquire
P.O. Box 22124
Hilton Head Island, SC 29925

Re: Wogan, Phyllis v. Kunze, Kenneth

Dear Counsel:

The Court has issued the following Order on your Petition for Rehearing in the above matter:

"Petition for Rehearing is denied.

s/ Jean H. Toal C.J.

s/ John H. Waller, Jr. J.

s/ Costa M. Pleicones J.

s/ Donald W. Beatty J.

Acting Justice James E. Moore not participating.

October 9, 2008."

The remittitur is today being forwarded to the lower court.

Very truly yours,

/s/ [Illegible]
CLERK

DES/dmh

cc: Elliott T. Halio, Esquire
Andrew S. Halio, Esquire
Mary Bass Lohr, Esquire
James S. Gibson, Jr., Esquire
Frederick A. Crawford, Esquire
Anthony E. Rebollo, Esquire
Johannes S. Kingma, Esquire
John C. Rogers, Esquire
Lenna S. Kirchner, Esquire

STATE OF SOUTH CAROLINA	IN THE COURT OF COMMON PLEAS
COUNTY OF BEAUFORT	FOURTEENTH JUDICIAL CIRCUIT
PHYLLIS J. WOGAN, individually and as Personal Representative of the ESTATE OF JAMES JOHN WOGAN, Plaintiff,	CASE NO.: 02-CP-07-1709
V.	AMENDED SUMMONS (JURY TRIAL REQUESTED)
KENNETH C. KUNZE, M.D.; HILTON HEAD GASTROENTEROLOGY, P.A.; THOMAS P. RZECZYCKI, M.D.; HILTON HEAD GENERAL, AND LAPAROSCOPIC SURGERY, P.A., GARY W. THOMAS, M.D. and GARY W. THOMAS, M.D., P.A. Defendants.	(Filed Feb. 13, 2004)

TO: THE ABOVE NAMED DEFENDANTS:

YOU ARE HEREBY SUMMONED and required to answer the Complaint in this action, a copy of which is herewith served upon you, and to serve a copy of your Answer to said Complaint on the subscribers hereunder at 7 Plantation Park Drive, Bluffton, South Carolina 29910 within thirty (30) days after the service hereof, exclusive of the day of such service; and if you fail to answer this Complaint

within the time aforesaid, the Plaintiff in this action will apply to the Court for the relief demanded in said Complaint.

The Law Office of
Duffie Stone, LLC

/s/ Isaac M. Stone
Isaac M. Stone, III
7 Plantation Park Drive
P.O. Box 155
Bluffton, South Carolina
29910
(843) 815-7800 (Phone)
(843) 815-7801 (Fax)

The Law Office of
Timothy W. Wogan, LLC

/s/ Timothy Wogan
Timothy M. Wogan
P.O. Box 22124
Hilton Head, South Carolina
29925
(843) 815-6921 (Phone
(843) 815-6931 (Fax)

Bluffton, South Carolina
February 16, 2004

STATE OF SOUTH CAROLINA COUNTY OF BEAUFORT	IN THE COURT OF COMMON PLEAS FOURTEENTH JUDICIAL CIRCUIT
PHYLLIS J. WOGAN, individually and as Personal Representative of the ESTATE OF JAMES JOHN WOGAN, Plaintiff, V. KENNETH C. KUNZE, M.D.; HILTON HEAD GASTROENTEROLOGY, P.A.; THOMAS P. RZECZYCKI, M.D.; HILTON HEAD GENERAL, AND LAPAROSCOPIC SURGERY, P.A., GARY W. THOMAS, M.D. and GARY W. THOMAS, M.D., P.A. Defendants.	CASE NO.: 02-CP-07-1709 AMENDED CIVIL ACTION COVERSHEET (JURY TRIAL REQUESTED) (Filed Feb. 18, 2004)

The cover sheet and the information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is required for the use of the Clerk of Court for the purpose of docketing. It must be filled out completely, signed and dated. **A copy of this cover sheet must be served on the Defendant(s) along with the Summons and Complaint.**

NATURE OF ACTION:
(Check one category for the main cause of action)

( ) TORT-Motor Vehicle
(X) TORT-Professional Malpractice
( ) TORT-Unfair Trade Practices, and other Business of Economic Wrongs
( ) TORT-Product Liability
( ) PCR
( ) GOV/ADM – Workers' Compenstation
( ) CONTRACT-Debt Collection
( ) CONTRACT-Employment
( ) CONTRACT-Construction
( ) CONTRACT-Wrongful Breach
( ) CONTRACT-General or Other
( ) REAL PROPERTY
( ) MINOR SETTLEMENT

JURY DEMANDED (X) YES ( ) NO

Note: Information requested on this form is preliminary in nature and for administrative purposes only. The response to this request for information on jury demand merely indicated the likelihood that a jury trial will or will not be requested and does NOT constitute a demand for a waiver of trial by jury pursuant to applicable rules or statutes.

DOCKETING INFORMATION: (Check one box)

( ) This case is subject to arbitration (all cases with monetary damages less than $25,000.00 are subject to arbitration, unless otherwise exempt).

(X) This case is subject to mediation (all cases not subject to arbitration must be mediated, unless otherwise exempt).

( ) This case is exempt from ADR, and certificate is attached.

The Law Office of
Duffie Stone, LLC

/s/ Isaac M. Stone
Isaac M. Stone, III
7 Plantation Park Drive
P.O. Box 155
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29910
(843) 815-7800 (Phone)
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Bluffton, South Carolina
February 16, 2004

The Law Office of
Timothy W. Wogan, LLC

/s/ Timothy Wogan
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STATE OF SOUTH CAROLINA COUNTY OF BEAUFORT PHYLLIS J. WOGAN, individually and as Personal Representative of the ESTATE OF JAMES JOHN WOGAN, Plaintiff, V. KENNETH C. KUNZE, M.D.; HILTON HEAD GASTROENTEROLOGY, P.A.; THOMAS P. RZECYCKI, M.D.; HILTON HEAD GENERAL AND LAPAROSCOPIC SURGERY, P.A., GARY W. THOMAS, M.D. and GARY W. THOMAS, M.D., P.A. Defendants.	IN THE COURT OF COMMON PLEAS FOURTEENTH JUDICIAL CIRCUIT CASE NO.: 02-CP-07-1709 **AMENDED COMPLAINT (JURY TRIAL REQUESTED)** (Filed Feb. 18, 2004)

TO: THE ABOVE NAMED DEFENDANTS:

COMES NOW, the Plaintiff, PHYLLIS J. WOGAN, individually and as Personal Representative of the ESTATE OF JAMES JOHN WOGAN, complaining of the following negligent and reckless acts and/or omissions of the Defendants, KENNETH C. KUNZE, M.D.; HILTON HEAD GASTRONTEROLOGY, P.A.; THOMAS P. RZECZYCKI, M.D.; HILTON

HEAD GENERAL AND LAPAROSCOPIC SURGERY, P.A.; GARY W. THOMAS, M.D. and GARY W. THOMAS, M.D., P.A. as follows:

FOR A FIRST CAUSE OF ACTION AS TO THE DEFENDANTS, KENNETH C. KUNZE, M.D.; HILTON HEAD GASTROENTEROLOGY, P.A.; THOMAS P. RZECZYCKI, M.D.; HILTON HEAD GENERAL AND LAPAROSCOPIC SURGERY, P.A.; GARY W. THOMAS, M.D. and GARY W. THOMAS, M.D., P.A.

(Negligence and Recklessness)

1. That the Parties hereto, the subject matter hereof and all matters and things hereinafter alleged are within the jurisdiction of this Honorable Court.

2. That the Plaintiff, PHYLLIS J. WOGAN, is now and was at all times material hereto a citizen and resident of Beaufort County, South Carolina.

3. That on or about October 11, 2001, the Plaintiff, PHYLLIS J. WOGAN, was duly appointed Personal Representative of the ESTATE OF JAMES JOHN WOGAN by the Beaufort County Probate Court; and that this Complaint is brought by the Plaintiff in her individual capacity, for her own benefit, and in her capacity as Personal Representative for the benefit of the ESTATE OF JAMES JOHN WOGAN.

4. That upon information and belief, the Defendant, KENNETH C. KUNZE, M.D., (hereinafter referred to as "KUNZE") is now and was at all times

material hereto a citizen and resident of Beaufort County, South Carolina.

5. That upon information and belief, the Defendant, KUNZE, is now and was at all times herein mentioned holding himself out to the public and, more particularly, to both the Plaintiff and Decedent as (1) a qualified physician in the field of Gastroenterology, having the education, training and skills possessed by other physicians practicing his specialty within the United States of America and more particularly with the State of South Carolina, and (2) as a licensed physician authorized to practice medicine under and pursuant to the laws of the State of South Carolina.

6. That at all times material hereto there existed a physician/patient relationship between the Defendant, KUNZE, and the Decedent, and by reason of any moral, contractual, confidential or fiduciary relationship, the Defendant, KUNZE, owed a duty of reasonable care and diligence in all aspects of his medical care, including but not limited to the diagnosis and treatment of the Decedent.

7. That the Defendant, KUNZE, is now and was, at all times herein mentioned, a staff member, employee and/or agent, either actual or apparent, of the Defendant, HILTON HEAD GASTROENTEROLOGY, P.A., and was acting within the course and scope of his employment and/or agency relationship with the Defendant, HILTON HEAD GASTROENTEROLOGY, P.A., on February 22, 2001, and thereafter.

8. That the Defendant, HILTON HEAD GASTROENTEROLOGY, P.A., is now, and was at all times hereinafter mentioned, a South Carolina corporation, partnership and/or professional association located and doing business in Beaufort County, South Carolina, was at all times hereinafter mentioned, holding itself out to the public in general and, more particularly, to both the Decedent and the Plaintiff as a corporation, partnership and/or professional association providing professional medical care and treatment to persons suffering from ailments of the digestive and related systems by skilled, educated, competent, experienced and qualified physicians licensed to practice medicine under and pursuant to the laws of the State of South Carolina and, more particularly, physicians with a specialty in the medical/surgical care and treatment of the digestive and related systems.

9. That at all times material hereto there existed a healthcare provider/patient relationship between the Defendant, HILTON HEAD GASTROENTEROLOGY, P.A., and the Decedent and, by reason of moral, contractual, confidential or fiduciary relationship, the Defendant, HILTON HEAD GASTROENTEROLOGY P.A., owed a duty of reasonable care and diligence in all aspects of the Decedent's medical care, including but not limited to the diagnosis and treatment of the Decedent and further owed a duty to provide skilled, educated, competent, experienced and qualified physicians licensed to practice medicine under and pursuant to the laws of the State

of South Carolina and more particularly with a specialty in the medical/surgical care and treatment of the digestive and related systems to its patients.

10. That upon information and belief, the Defendant, THOMAS P. RZECZYCKI, M.D., (hereinafter referred to as "RZECYCKI") is now and was at all times material hereto a citizen and resident of Beaufort County, South Carolina.

11. That upon information and belief, the Defendant, RZECZYCKI, is now and was at all times herein mentioned holding himself out to the public and, more particularly to both the Plaintiff and Decedent as (1) a qualified physician in the field of general surgery, having the education, training and skills possessed by other physicians practicing his specialty within the United States of America and more particularly within the State of South Carolina, and (2) as a licensed physician authorized to practice medicine under and pursuant to the laws of the State of South Carolina.

12. That at all times material hereto there existed a physician/patient relationship between the Defendant, RZECZYCKI, and the Decedent and, by reason of moral, contractual, confidential or fiduciary relationship, the Defendant, RZECZYCKI, owed a duty of reasonable care and diligence in all aspects of the Decedent's medical and surgical care, including but not limited to the diagnosis and treatment of the Decedent.

13. That the Defendant, RZECZYCKI, was, at all times herein mentioned, a staff member, employee and/or agent, either actual or apparent, of the Defendant, HILTON HEAD GENERAL AND LAPAROSCOPIC SURGERY, P.A., and was acting within the course and scope of his employment and/or agency relationship with the Defendant, HILTON HEAD GENERAL AND LAPAROSCOPIC SURGERY, P.A., on March 19, 2001 and thereafter.

14. That the Defendant, HILTON HEAD GENERAL AND LAPAROSCOPIC SURGERY, P.A., is now, and was at all times hereinafter mentioned, a South Carolina corporation, partnership and/or professional association located and doing business in Beaufort County, South Carolina, was at all times hereinafter mentioned, holding itself out to the public in general and, more particularly, to both the Decedent and Plaintiff as a medical corporation, partnership and/or professional association providing professional medical/surgical care and treatment to persons suffering from medical ailments and, more specifically, in need of surgical intervention by skilled, educated, competent, experienced and qualified physicians/surgeons licensed to practice medicine under and pursuant to the laws of the State of South Carolina and more particularly medical physicians with a specialty in surgery.

15. That at all times material hereto there existed a healthcare provider/patient relationship between the Defendant, HILTON HEAD GENERAL AND LAPAROSCOPIC SURGERY, P.A., and the

Decedent, JAMES JOHN WOGAN, and, by reason of moral, contractual, confidential or fiduciary relationship, the Defendant, HILTON HEAD GENERAL AND LAPAROSCOPIC SURGERY P.A., owed a duty of reasonable care and diligence in the medical and surgical care of the Decedent, including diagnosis and treatment of the Decedent and further owed a duty of to provide skilled, educated, competent, experienced and qualified physicians/surgeons licensed to practice medicine under and pursuant to the laws of the State of South Carolina and more particularly medical physicians with a specialty in surgery.

16. That upon information and belief, the Defendant, GARY W. THOMAS, M.D., (hereinafter referred to as "THOMAS") is now and was at all times material hereto a citizen and resident of Beaufort County, South Carolina.

17. That upon information and belief, the Defendant, THOMAS, is now and was at all times herein mentioned holding himself out to the public and, more particularly, to both the Plaintiff and Decedent as (1) a qualified physician in the field of internal medicine, oncology and hematology, having the education, training and skills possessed by other physicians practicing his specialty within the United States of America and more particularly within the State of South Carolina, and (2) as a licensed physician authorized to practice medicine under and pursuant to the laws of the State of South Carolina.

18. That at all times material hereto there existed a physician/patient relationship between the Defendant, THOMAS, and the Decedent, and by reason of any moral, contractual, confidential or fiduciary relationship, the Defendant, THOMAS, owed a duty of reasonable care and diligence in all aspects of his medical care, including but not limited to the diagnosis and treatment of the Decedent.

19. That the Defendant, THOMAS, is now and was at all times after April 1, 2001, a staff member, employee and/or agent, either actual or apparent, of the Defendant, GARY W. THOMAS, M.D., P.A., and was acting within the course and scope of his employment and/or agency relationship with the Defendant, GARY W. THOMAS, M.D., P.A., on April 1, 2001, and thereafter.

20. That the Defendant, GARY W. THOMAS, M.D., P.A., is now, and was at all times after April 1, 2001, a South Carolina corporation, partnership and/or professional association located and doing business in Beaufort County, South Carolina, was at all times hereinafter mentioned, holding itself out to the public in general and, more particularly, to both the Decedent and the Plaintiff as a corporation, partnership and/or professional association providing professional medical care and treatment to persons suffering from medical ailments by skilled, educated, competent, experienced and qualified physicians licensed to practice medicine under and pursuant to the laws of the State of South Carolina and, more

particularly, physicians with a specialty in internal medicine, oncology and hematology.

21. That at all times after April 1, 2001 there existed a healthcare provider/patient relationship between the Defendant, GARY W. THOMAS, M.D., P.A., and the Decedent and, by reason by moral, contractual, confidential or fiduciary relationship, the Defendant, GARY W. THOMAS, M.D., P.A., owed a duty of reasonable care and diligence in all aspects of the Decedent's medical care, including but not limited to the diagnosis and treatment of the Decedent and further owed a duty to provide skilled, educated, competent, experienced and qualified physicians licensed to practice medicine under and pursuant to the laws of the State of South Carolina and more particularly with a specialty in internal medicine, hematology and oncology.

22. That upon information and belief, the Defendants, KUNZE and THOMAS, and the Defendants, HILTON HEAD GASTROENTEROLOGY, P.A. and GARY W. THOMAS, M.D., P.A., are now and were at all times material hereto, physicians and/or health care providers that participated in the Federal Medicare Program; that upon information and belief, such program has a mandatory claim submission rule and/or regulation which required the Defendants, KUNZE; THOMAS; HILTON HEAD GASTROENTEROLOGY, P.A.; and/or GARY W. THOMAS, M.D., P.A. to submit a Medicare claim when requested by or on behalf of a Medicare beneficiary.

23. That on or about January 28, 2001, the Decedent, JAMES JOHN WOGAN, while under the care of the Defendant, THOMAS, began a course of palliative radiation therapy directed and supervised by radiologist Kenneth T. Strike, M.D.

24. That on or about February 9, 2001, Kenneth T. Strike, M.D., terminated the Decedent's radiation treatment(s) due to the development of persistent high output/high frequency diarrhea that began approximately seven (7) days earlier.

25. That between February 9, 2001, and February 22, 2001, the Decedent continued to experience severe diarrhea and remained under the care and treatment of the Defendant, THOMAS, for said medical ailment.

26. That on or about February 22, 2001, the Defendant, THOMAS, admitted the Decedent to Hilton Head Hospital for dehydration and volume depletion secondary to a twenty (20) day history of profuse, persistent, watery diarrhea.

27. That upon admission, the Defendant, THOMAS, requested a consultation from the Defendant, KUNZE, a gastroenterologist associated with the Defendant, HILTON HEAD GASTROENTEROLOGY, P.A..

28. That on February 23, 2001, the Defendant, KUNZE, performed a sigmoidoscope and diagnosed the Decedent with a fecal impaction.

29. That the Defendant, KUNZE and/or the Defendant, THOMAS, ordered that the Decedent be taken back to his hospital room and treated with water enemas.

30. That despite the diarrhea continuing, the Defendant, KUNZE, and/or the Defendant, THOMAS, discharged the Decedent home without performing any further diagnostic testing to determine the status and/or condition of the Decedent's digestive system even though one or both considered radiation injury as a possible cause of the Decedent's medical condition.

31. That for the next eleven (11) days, while at home, the Decedent, JAMES JOHN WOGAN, continued to experience as many as twenty (20) episodes a day of high output diarrhea.

32. That on or about March 5, 2001, the Defendant, THOMAS, again admitted the Decedent, JAMES JOHN WOGAN, to Hilton Head Hospital with an admitting complaint of dehydration and malnutrition secondary to a thirty (30) day history of severe and debilitating diarrhea.

33. That upon admission, the Defendant, THOMAS, again requested a consultation from the Defendant, KUNZE.

34. That upon information and believe the Defendant, THOMAS and the Defendant, KUNZE, again considered radiation injury as a possible cause of the Decedent's medical condition.

35. That on March 6, 2001, the Defendant, KUNZE, performed a colonoscopy and found an area of ulceration in the Decedent's rectosigmoid colon.

36. That, although still his patient and for an unknown reason, on March 8, 2001, the Defendant, THOMAS, transferred the responsibility of the Decedent's care and treatment to the Defendant, KUNZE, for the remainder of the hospitalization.

37. That between March 8, 2001 and March 11, 2001, the Defendant, THOMAS, failed to provide any further care or treatment to the Decedent during his hospitalization.

38. That between March 8, 2001 and March 11, 2001, the Defendant, KUNZE, failed to perform any further diagnostic testing to determine the status and/or condition of the Decedent's digestive system.

39. That on March 11, 2001, the Defendant, KUNZE, discharged the Decedent from the hospital.

40. That for the next nine (9) days, while at home, the Decedent, JAMES JOHN WOGAN, continued to experience as many as twenty (20) episodes a day of high output diarrhea.

41. That at approximately 11:00 p.m., March 19, 2001, after several unsuccessful attempts to reach the Defendant, KUNZE, the Plaintiffs, PHYLLIS J. WOGAN, called the Defendant, THOMAS, to inform him that the Decedent was again very dehydrated and was extremely weak due to the diarrhea; and that the Defendant, THOMAS, instructed her to take

the Decedent to Hilton Head Hospital Emergency Room for evaluation.

42. That on March 19, 2001, at approximately 12:13 a.m., after approximately forty-five (45) days of continuous high output/high frequency diarrhea, the Decedent was again admitted to the Hilton Head Hospital Emergency Room for malnutrition and diarrhea; that upon admission Michael Kulp, M.D., an emergency room physician, noted that "the [Decedent's] diarrhea persists. On a daily basis has twenty (20) to twenty five (25) stools . . . They [the Plaintiff] called Dr. Gary Thomas this evening after they could not get a hold of Dr. Kunze all day . . . The [Decedent] has been previously admitted on Gary W. Thomas, M.D., service with Dr. Kunze consulting . . . however Dr. Thomas feels that this problem is no longer related to the cancer and feels that he may be best taken care of by an internist;" and that Michael Kulp, M.D., admitted the Decedent to Hilton Head Hospital under the care and treatment of the Defendant, KUNZE.

43. That upon the Decedent's admission to the medical/surgical floor of Hilton Head Hospital, the Defendant, KUNZE, simultaneously requested a CT scan of the Decedent's abdomen and a surgical consultation from the Defendant, RZECZYCKI, a surgeon associated with the Defendant, HILTON HEAD GENERAL AND LAPAROSCOPIC SURGERY, for the permanent surgical diversion of the Decedent's colon.

44. That on March 21, 2001, the Defendant, RZECZYCKI, performed the three (3) hour surgical diversion and transferred the Decedent to the Intensive Care Unit of Hilton Head Hospital.

45. That the Defendant, RZECZYCKI, failed to perform a history and physical upon the Decedent prior to the performance of the above referenced surgical diversion.

46. That between March 21, 2001, and March 29, 2001, the Decedent, JAMES JOHN WOGAN's, diarrhea resumed and continued to flow out his rectum, despite the surgical diversion of his colon.

47. That on or about March 29, 2001, after the Defendant, RZECZYCKI, notified the Plaintiff, PHYLLIS J. WOGAN, that the Decedent would be discharged the next morning, the Plaintiff insisted that she was not taking the Decedent home until the Defendants found out what was causing the Decedent's diarrhea and why it was flowing out his rectum despite his colon being diverted eight days earlier.

48. That shortly after the Plaintiff insisted that the Defendants find out what was causing the Defendant's diarrhea, the Defendant, RZECZYCKI, ordered a barium enema to be performed the following morning.

49. That on March 30, 2001, the Defendant, RZECZYCKI, informed the Plaintiff and the Decedent that the barium enema revealed a fistula between the Decedent's small intestine and his rectum and that

the diarrhea was caused by gastric contents flowing from the Decedent's small intestine into the rectal stump and out his rectum.

50. That the surgical diversion of the Decedent's colon ordered by the Defendant, KUNZE, and performed by the Defendant; RZECZYCKI, was unnecessary.

51. That the surgical diversion of the Decedent's colon ordered by the Defendant, KUNZE, and performed by the Defendant, RZECZYCKI, completely failed to cure the Decedent's diarrhea.

52. That although still his patient, the Defendant, THOMAS, did not assess, treat or examine the Decedent between the date of the Decedent's hospital admission, March 19, 2001 and the date of the Decedent's hospital discharge, March 30, 2001.

53. That the fistula that caused the Decedent's diarrhea was easily detectable prior to the surgical diversion, by one, more or all of the Defendants, and could have been treated without surgical intervention.

54. That on March 30, 2001, the Defendant, RZECZYCKI, discharged the Decedent from the hospital while still suffering diarrhea out of his rectum. Additionally, the Defendant, RZECZYCKI, and/or the Defendant, KUNZE discharged the Decedent without ordering prophylactic anticoagulant therapy, when they knew or should have known that such therapy was necessary, prudent and reasonable

based on the Decedent's significant past history of deep vein thrombosis subsequent to abdominal surgery.

55. That the Defendant, RZECZYCKI, instructed the Plaintiff and the Decedent to wait for a phone call from the Defendant, KUNZE, regarding treatment options for the diarrhea.

56. That the Defendant, KUNZE, employed an office nurse who is now and was, at all times herein mentioned, a staff member, employee and/or agent, either actual or apparent, of the Defendant, HILTON HEAD GASTROENTEROLOGY, P.A., and the Defendant, KUNZE and was acting within the course and scope of her employment and/or agency relationship with the Defendant, HILTON HEAD GASTROENTEROLOGY, P.A., and the Defendant, KUNZE on February 22, 2001, and thereafter.

57. That on or about April 5, 2001, KUNZE's office nurse informed the Plaintiff that Glenn P. Gwozdz, M.D., an associate of the Defendant, KUNZE, prescribed the Decedent an injectable medication by the trade name of Sandostatin SC for treatment of the Decedent's diarrhea.

58. That KUNZE's office nurse instructed the Plaintiff to purchase the medication at the pharmacy and to administer it to the Decedent at home.

59. That the Plaintiff did as instructed and purchased the medication at a cost of approximately

One Thousand Two Hundred ($1,200.00) Dollars per month.

60. That within eight hours of his first injection the Decedent's diarrhea ceased.

61. Upon information and belief, Sandostatin SC is not required to be given under the supervision of a physician and is not a "covered drug" under the Federal Medicare program.

62. That on or about April 12, 2001 during a post-operative office examination, the Defendant, KUNZE, informed the Plaintiff and the Decedent that, effective May 25, 2001, KUNZE was going to change the Decedent's medication to Sandostatin LAR, a long acting form of the Sandostatin SC.

63. That the Defendant, KUNZE, further informed the Plaintiff and the Decedent that Sandostatin LAR would be administered once a month in his office, via an intramuscular injection; and that, unlike Sandostatin SC, it was a "covered drug" under the Medicare program and that a Medicare claim would be submitted.

64. That the manufacturer of Sandostatin LAR requires the medication be mixed and administered under the supervision of a physician and requires periodic blood level monitoring.

65. That on or about April 27, 2001, KUNZE's office nurse informed the Plaintiff that the Defendant, KUNZE, had phoned a three (3) month prescription of Sandostatin LAR into a local pharmacy.

66. That KUNZE's office nurse instructed the Plaintiff to purchase the medication at the pharmacy each month and give it to the Decedent at home.

67. That the instruction to purchase the medication at the pharmacy each month and give it to the Decedent at home originated from the Defendant, KUNZE.

68. That the Plaintiff inquired as to why the medication would not be given in the office and why a claim would not be submitted to Medicare, as previously discussed.

69. That KUNZE's office nurse stated that because the medication was so expensive neither the Defendant, KUNZE, nor the Defendant, HILTON HEAD GASTORENTEROLOGY, P.A., would purchase the medication nor submit a Medicare claim on behalf of the Decedent, further the Defendant, KUNZE, either individually or by and through his office nurse told the Plaintiff to call the Decedent's other physician, the Defendant, THOMAS, and ask him to prescribe the medication and submit the claim to Medicare.

70. That this refusal and instruction originated from the Defendant, KUNZE.

71. That on or about April 19, 2001, the Plaintiff did as instructed and made a request to the Defendant, THOMAS, to prescribe the medication and submit a claim.

72. That although, still his patient, the Defendant, THOMAS, informed the Plaintiff that he would not prescribe the medication for the Decedent and would not submit a claim to Medicare; and that the Defendant, THOMAS, further instructed the Plaintiff to go back to the Defendant, KUNZE'S, office and work it out with them.

73. That after continuous insistence by the Plaintiff that the medication be given under the supervision of a physician, as required, KUNZE's, office nurse relented and informed the Plaintiff that someone in the Defendant, KUNZE'S, office would administer it to the Decedent.

74. That the Defendants, KUNZE and/or HILTON HEAD GASTROENTEROLOGY, P.A., required the Decedent and/or the Plaintiff to purchase Sandostatin LAR and bring it into the office.

75. That this requirement originated from the Defendant, KUNZE.

76. That sometime shortly after April 27, 2001, the Plaintiff phoned the local pharmacy and was informed that the retail cost of the Sandostatin LAR was Two Thousand Seven Hundred Seventy Eight Dollars and Ninety Nine ($2,779.99) Cents per injection.

77. That on or about May 7, 2001, the Defendant, THOMAS, admitted the Decedent to Hilton Head Hospital for a deep vein clot where he remained until on or about May 9, 2001; that although he

would not prescribe the Sandostatin for the Decedent out of his office, he did prescribe the Sandostatin while the Decedent was a patient in the Hilton Head Hospital; that the Plaintiff is informed and believes that this hospitalization is the direct of the unnecessary surgical procedure of March 21, 2001, the resulting ten (10) day hospitalization and/or the failure of the Defendant, KUNZE and/or the Defendant, RZECZYCKI, to provide the Decedent with prophylactic anticoagulant therapy prior to and subsequent to his discharge from the March 19, 2001, through March 30, 2001, hospitalization.

78. That between May 9, 2001 and July 12, 2001, the Plaintiff and/or the Decedent made numerous written and verbal requests to the Defendants, KUNZE and THOMAS, for their assistance in gaining Medicare reimbursement for the purchase price of the Sandostatin LAR.

79. That the Defendant, KUNZE and THOMAS, repeatedly failed to answer and/or acknowledge their requests for assistance and failed to submit a Medicare claim as required.

80. That during the above referenced time period, the Plaintiff and the Decedent were repeatedly told by the Defendant, KUNZE, that the Defendant, THOMAS, should prescribe the medication and submit the claim to Medicare and were repeatedly told by the Defendant, THOMAS, that the Defendant, KUNZE, should prescribe the medication and submit the claim to Medicare.

81. That on or about July 12, 2001, Paul Slota, M.D., admitted the Decedent, JAMES JOHN WOGAN, to Hilton Head Hospital for Coumadin coagulopathy, where he remained until on or about July 13, 2001, and that this hospitalization was the direct result of the unnecessary surgical procedure of March 21, 2001, the resulting ten (10) day hospitalization and/or the failure of the Defendant, KUNZE and/or the Defendant, RZECZYCKI, to provide the Decedent with prophylactic anticoagulant therapy prior to and subsequent to his discharge from the March 19, 2001, through March 30, 2001, hospitalization.

82. That between July 13, 2001, and September 30, 2001, the Plaintiff and/or the Decedent again made numerous written and verbal requests to the Defendants, KUNZE and THOMAS, for their assistance in gaining Medicare reimbursement for the purchase price of the Sandostatin LAR, that the Defendants, KUNZE and THOMAS, repeatedly failed to answer and/or acknowledge their requests for assistance, repeatedly informed the Plaintiff and the Decedent that the other should prescribe the medication and throughout this time period both the Defendant, KUNZE and the Defendant, THOMAS failed to submit a Medicare claim, as, upon information and belief, they were required to do.

83. That on or about September 25, 2001, due to the Decedent's imminent death, the Defendant, THOMAS, ordered hospice care for the Decedent to be provided at home.

84. That on September 28, 2001 at approximately 2:00 a.m., the Defendant, THOMAS, was telephoned and informed by a hospice nurse that the Decedent was suffering from excruciating pain due to bone cancer, that he was unable to swallow pain medication and that he was in a "pain crisis" and needed liquid morphine.

85. That the Defendant, THOMAS, failed and/or refused to write a prescription for the liquid morphine at that time and instead offered an appointment in his office the following morning or, as an alternative, informed the hospice nurse to call the emergency room to see if the emergency room physician would prescribe the pain medication.

86. That between 2:00 a.m. and 8:00 a.m. the Decedent suffered horrible and excruciating pain from his bone cancer without the benefit of pain medication.

87. That at 8:00 a.m. September 29, 2001, the Defendant, THOMAS, faxed a prescription to the local pharmacy for liquid morphine, which was picked up and administered to the Decedent thereby relieving his pain.

88. That on or about October 1, 2001, after seven (7) months of expensive pain and suffering secondary to substandard medical care, unnecessary surgical diversion of his colon, avoidable hospitalizations and constant emotional and psychological worry over excessive medication costs, the Decedent died.

89. That the injuries and damages suffered by the Plaintiff, PHYLLIS J. WOGAN, individually and as Personal Representative of the ESTATE OF JAMES JOHN WOGAN, were due to and caused by and were the direct and proximate result of the carelessness, negligence, willfulness, wantonness, heedlessness and recklessness of one (1) or more of the Defendants, KENNETH C. KUNZE, M.D.; HILTON HEAD GASTROENTEROLOGY, P.A.; THOMAS P. RZECZYCKI, M.D., HILTON HEAD GENERAL AND LAPAROSCOPIC SURGERY, P.A.; GARY W. THOMAS, M.D.; and GARY W. THOMAS, M.D., P.A and each of them jointly and severally, whether singularly, concurrently or in combination, by reason or any apparent agency or contractual business or other relationship, in one (1) or more of the following particulars, to wit:

AS TO THE DEFENDANT, KENNETH C. KUNZE M.D.

a. Between February 22, 2001 and March 21, 2001, in failing to obtain a complete, thorough and accurate medical history for the Decedent and, if obtained, in failing to appreciate his medical history, which was highly indicative of small bowel injury or fistula formation;

b. Failing to perform a thorough, complete and detailed physical examination upon the Decedent between February 22, 2001 and March 21, 2001, and, if obtained, in

failing to appreciate the findings of the Decedent's physical examination;

c. Between February 22, 2001 and March 21, 2001, in failing to fully consider and appreciate the medical signs and symptoms presented by the Decedent, which were highly indicative of small bowel injury or fistula formation;

d. Between February 22, 2001 and March 21, 2001, in failing to perform or to have performed appropriate diagnostic tests on the Decedent, including but not limited to a barium enema and/or gastographin enema, water soluble enema and/or a small bowel x-ray one or more of which were indicated, given the Decedent's history and presenting signs and symptoms, and would have most probably detected the Decedent's fistula prior to the surgical diversion of his colon;

e. Between February 22, 2001 and March 21, 2001, in failing to make a correct diagnosis of the Decedent's medical condition, specifically in failing to diagnose a small bowel injury and/or small bowel-rectal fistula, so as to prevent and/or avoid unnecessary surgical procedures and hospitalizations;

f. In failing to provide appropriate gastroenterological care and treatment to the Decedent between February 22, 2001 and March 31, 2001;

g. In failing to reassess the Decedent's diagnosis, care and/or treatment periodically between February 22, 2001 and March 21, 2002 in sufficient time to prevent and/or avoid unnecessary surgical procedures and hospitalizations

h. Between February 22, 2001 and March 19, 2001, in failing to realize and/or appreciate the Decedent's impending nutritional crisis and to take steps to address this condition;

i. Between March 5, 2001 and March 21, 2001, in negligently and recklessly failing to order any appropriate diagnostic test to eliminate and/or support his differential diagnosis of radiation injury to the small bowel, including but not limited to small bowel studies, barium enemas, water soluble enemas and/or small bowel x-rays, all of which most probably would have shown small bowel injury and/or fistula formation;

j. On March 6, 2001, in failing to appreciate the significant endoscopic finding of an "ulcerated area" in the Decedent's colon and failing to order additional diagnostic testing to further delineate and define the "ulcerated area" and determine if it was a fistula;

k. On March 19, 2001, in negligently referring the Decedent to a surgeon for surgical diversion of his colon when he knew or should have known, in the exercise of reasonable care, that such procedure was not

indicated and would not resolve the Decedent's severe and debilitating diarrhea as it was most probably caused by a fistula and not an obstructive process;

l. In failing to consider and attempt less aggressive and invasive means of controlling the Decedent's severe and debilitating diarrhea prior to ordering extensive abdominal surgery and permanent diversion of the Decedent's colon;

m. In negligently and recklessly failing to place the Decedent on anticoagulant medication subsequent to his surgery and thereby causing two (2) subsequent hospitalizations, specifically, May 7-9, 2001 and July 12-13, 2001;

n. In negligently and recklessly failing to address the constant pleas from the Decedent and the Plaintiff for help in submitting a Medicare claim;

o. In negligently and recklessly failing to submit a Medicare claim on or about May 25, 2001, on or about June 22, 2001, on or about July 20, 2001, on or about August 24, 2001 and thereafter;

p. In negligently and recklessly putting personal and professional profits before the health, welfare and safety of his patients;

q. In failing to possess and/or exercise that degree of medical knowledge, training, experience, skill and/or care in the diagnosis, care and treatment of the Decedent which

was ordinarily possessed or exercised by other physicians in good standing similarly situated under the same or similar circumstances;

r. In departing from generally accepted standards of clinical medical practice, knowledge and skill which is generally accepted throughout the United States, including the State of South Carolina, in the administration of its diagnosis, care and treatment rendered to the public, more particularly, rendered to the Decedent herein;

s. In negligently and recklessly failing to exercise ordinary or even slight care in the diagnosis, care and treatment of the Decedent;

AS TO THE DEFENDANT, HILTON HEAD GASTROENTEROLOGY, PA

t. The specific allegations set forth against the Defendant, KENNETH C. KUNZE, M.D., as the apparent or ostensible agent of the Defendant, HILTON HEAD GASTROENTEROLOGY, P.A., contained in paragraphs One (1) through Eighty Nine (89) and subparts (A) through (S) are hereby repeated and realleged and incorporated into this paragraph and imputed against the Defendant, HILTON HEAD GASTROENTEROLOGY, P.A., as if fully set forth herein verbatim wherein that

said Defendant, HILTON HEAD GASTROENTEROLOGY, P.A., is responsible and vicariously liable for the negligent and reckless acts or omissions of its employees and or agents, including but not limited to the Defendant, KENNETH C. KUNZE, M.D., and thus liable to the Plaintiff herein;

u. In failing to establish and enforce appropriate and effective professional association and medical, financial and billing policies, procedures and/or standards applicable to all physicians or other employees and/or agents associated with or employed by the Defendant, HILTON HEAD GASTROENTEROLOGY, P.A., including the Defendant, KENNETH C. KUNZE, M.D., which would have protected the public and more particularly the Decedent herein, from inappropriate, improper, negligent and reckless diagnosis, care and treatment and billing administration;

v. In departing from generally accepted standards of clinical medical practice, knowledge and skill which is generally accepted throughout the United States, including the State of South Carolina, in the administration of its diagnosis, care and treatment rendered to the public, more particularly, rendered to the Decedent herein;

w. In failing to provide a knowledgeable and skilled medical physician to adequately, appropriately and timely, observe, assess and/or evaluate the Decedent during the course of his gastrointestinal illness;

x. In failing to possess and/or exercise that degree of knowledge, care and skill in the diagnosis, care and treatment of the Decedent between February 21, 2001 and October 1, 2001; and

y. In failing to exercise ordinary or even slight care in the management, control and supervision of its business, including its agents, employees and principals.

AS TO THE DEFENDANT, THOMAS P. RZECZYCKI, M.D.

z. On March 19 through March 30, 2001 and thereafter, in departing from generally accepted standards of medical and surgical practice in the diagnosis, care and treatment of the Decedent by failing to follow one or more or all of the following steps, guidelines, and/or standards:

1. In failing to obtain and/or know the complete medical history or the Decedent;

2. In failing to perform a thorough physical examination upon the Decedent;

3. In failing to perform or to have performed, appropriate diagnostic tests

on the Decedent, including but not limited to barium enemas, small bowel studies, water soluble enemas and/or small bowel x-rays and to take immediate and appropriate action so as to prevent injury to the Decedent;

4. In failing to make a correct differential diagnosis of the condition of the Decedent;

5. In failing to make a correct diagnosis of the condition of the Decedent so as to prevent or avoid further debilitating and unnecessary diagnostic and/or surgical procedures and further costs;

6. In failing to provide appropriate surgical care and treatment to the Decedent; and

7. In failing to reassess the diagnosis and/or treatment periodically or in sufficient time to prevent and/or avoid debilitating and unnecessary diagnostic and/or surgical procedures and further costs.

aa. In negligently and recklessly failing to obtain informed consent to perform a side-by-side small bowel anastomosis during the March 22, 2001, surgery;

bb. In negligently and recklessly failing to place the Decedent on anticoagulant medication subsequent to his surgery and

thereby causing two (2) subsequent hospitalizations, specifically, May 7-9, 2001 and July 12-13, 2001;

cc. In negligently and recklessly failing to perform his own history and physical to determine the medical necessity of a surgical diversion of the Decedent's colon and instead relying on the Defendant, KENNETH C. KUNZE's, determination of such;

dd. In failing to possess and/or exercise that degree of medical knowledge, training, experience, skill and/or care in the diagnosis, care and treatment of the Decedent, JAMES JOHN WOGAN, which was ordinarily possessed or exercised by other physicians in good standing similarly situated under the same or similar circumstances;

ee. In departing from generally accepted standards of clinical medical practice, knowledge and skill which is generally accepted throughout the United States, including the State of South Carolina, in the administration of its diagnosis, care and treatment rendered to the public, more particularly, rendered to the Decedent herein;

ff. In negligently and recklessly failing to exercise ordinary or even slight care in the diagnosis, care and treatment of the Decedent;

AS TO THE DEFENDANT, HILTON HEAD GENERAL AND LAPAROSCOPIC SURGERY, P.A.

gg. The specific allegations set forth against the Defendant, THOMAS P. RZECZYCKI, M.D., as the apparent or ostensible agent of the Defendant, HILTON HEAD GENERAL AND LAPAROSCOPIC SURGERY, P.A., contained in paragraphs One (1) through Eighty Nine (89) and subparts (Z) through (FF) are hereby repeated and realleged and incorporated into this paragraph and imputed against the Defendant, HILTON HEAD GENERAL AND LAPAROSCOPIC SURGERY, P.A., as if fully set forth herein verbatim wherein that said Defendant, HILTON HEAD GENERAL AND LAPAROSCOPIC SURGERY, P.A., is responsible and vicariously liable for the negligent and reckless acts or omissions of its employees and or agents, including but not limited to the Defendant, KENNETH C. KUNZE, M.D., and thus liable to the Plaintiff herein;

hh. In failing to establish and enforce appropriate and effective professional association and medical policies, procedures and/or standards applicable to all physicians associated with or employed by the Defendant, HILTON HEAD GENERAL AND LAPAROSCOPIC SURGERY, P.A., including the Defendant, THOMAS P. RZECZYCKI, M.D., which would have protected the public and more particularly the

Decedent herein, from inappropriate, improper, negligent and reckless diagnosis, care and treatment;

ii. In departing from generally accepted standards of clinical medical practice, knowledge and skill which is generally accepted throughout the United States, including the State of South Carolina; in the administration of its diagnosis, care and treatment rendered to the public, more particularly, rendered to the Decedent herein;

jj. In failing to provide a knowledgeable and skilled medical physician to adequately, appropriately and timely, observe, assess and/or evaluate the Decedent during the course of his gastrointestinal illness;

kk. In failing to possess and/or exercise that degree of care and skill in the diagnosis, care and treatment of the Decedent between February 19, 2001 and October 1, 2001 and;

ll. In failing to exercise ordinary or even slight care in the management, control and supervision of its business, agents, employees and principals.

AS TO THE DEFENDANT GARY W. THOMAS, M.D.

mm. Between February 22, 2001 and March 19, 2001, in failing to obtain a complete, thorough and accurate medical history for the

Decedent and, if obtained, in failing to appreciate his medical history, which was highly indicative of small bowel injury or fistula formation;

nn. Failing to perform a thorough, complete and detailed physical examination upon the Decedent between February 22, 2001 and March 19, 2001, and, if obtained, in failing to appreciate the findings of the Decedent's physical examination;

oo. Between February 22, 2001 and March 19, 2001, in failing to fully consider and appreciate the medical signs and symptoms presented by the Decedent, which were highly indicative of small bowel injury or fistula formation;

pp. Between February 22, 2001 and March 19, 2001, in failing to perform or to have performed appropriate diagnostic tests on, the Decedent, including but not limited to a barium enema and/or gastographin enema, water soluble enema and/or a small bowel x-ray one or more of which were indicated, given the Decedent's history and presenting signs and symptoms, and would have most probably detected the Decedent's fistula prior to the surgical diversion of his colon;

qq. Between February 22, 2001 and March 19, 2001, in failing to make a correct diagnosis of the Decedent's medical condition, specifically in failing to diagnose a small bowel injury and/or small bowel-rectal fistula,

so as to prevent and/or avoid unnecessary surgical procedures and hospitalizations;

rr. In failing to provide appropriate medical care and treatment to the Decedent between February 22, 2001 and October 1, 2001;

ss. In failing to reassess the Decedent's diagnosis, care and/or treatment periodically between February 22, 2001 and March 19, 2001 in sufficient time to prevent and/or avoid unnecessary surgical procedures and hospitalizations

tt. Between February 22, 2001 and March 19, 2001, in failing to realize and/or appreciate the Decedent's impending nutritional crisis and to take steps to address this condition;

uu. Between February 22, 2001 and March 11, 2001, in negligently and recklessly prescribing medications for the Decedent, which were contraindicated for his condition;

vv. Between March 5, 2001 and March 19, 2001, in negligently and recklessly failing to order any appropriate diagnostic test to eliminate and/or support his differential diagnosis of radiation injury to the small bowel, including but not limited to small bowel studies, barium enemas, water soluble enemas and/or small bowel x-rays, all of which most probably would have shown small bowel injury and/or fistula formation;

ww. On March 6, 2001, in failing to appreciate the significant endoscopic finding of an "ulcerated area" in the Decedent's colon and failing to order additional diagnostic testing to further delineate and define the "ulcerated area" and determine if it was a fistula;

xx. In negligently and recklessly failing to address the constant pleas from the Decedent and the Plaintiff for help in submitting a Medicare claim;

yy. In negligently and recklessly failing to submit a Medicare claim on or about May 25, 2001, on or about June 22, 2001, on or about July 20, 2001, on or about August 24, 2001 and thereafter;

zz. In negligently and recklessly failing to control the Decedent excruciating pain from bone cancer;

aaa. In negligently and recklessly putting personal and professional profits before the health, welfare and safety of his patients;

bbb. In failing to possess and/or exercise that degree of medical knowledge, training, experience, skill and/or care in the diagnosis, care and treatment of the Decedent which was ordinarily possessed or exercised by other physicians in good standing similarly situated under the same or similar circumstances;

ccc. In departing from generally accepted standards of clinical medical practice, knowledge and skill which is generally accepted throughout the United States, including the State of South Carolina, in the administration of its diagnosis, care and treatment rendered to the public, more particularly, rendered to the Decedent herein;

ddd. In negligently and recklessly failing to exercise ordinary or even slight care in the diagnosis, care and treatment of the Decedent;

AS TO THE DEFENDANT, GARY W. THOMAS, M.D., P.A.

eee. The specific allegations set forth against the Defendant, GARY W. THOMAS, M.D., as the apparent or ostensible agent of the Defendant, GARY W. THOMAS, M.D., P.A., contained in paragraphs One (1) through Eighty Nine (89) and subparts (MM) through (ddd) are hereby repeated and realleged and incorporated into this paragraph and imputed against the Defendant, GARY W. THOMAS, M.D., P.A., as if fully set forth herein verbatim wherein that said Defendant, GARY W. THOMAS, M.D., P.A., is responsible and vicariously liable for the negligent and reckless acts or omissions of its employees and or agents, including but not limited to

the Defendant, GARY W. THOMAS, M.D., and thus liable to the Plaintiff herein;

fff. In failing to establish and enforce appropriate and effective professional association and medical, financial and billing policies, procedures and/or standards applicable to all physicians or other employees and/or agents associated with or employed by the Defendant, GARY W. THOMAS, M.D., P.A., including the Defendant, GARY W. THOMAS, M.D., which would have protected the public and more particularly the Decedent herein, from inappropriate, improper, negligent and reckless diagnosis, care and treatment and billing administration;

ggg. In departing from generally accepted standards of clinical medical practice, knowledge and skill which is generally accepted throughout the United States including the State of South Carolina, in the administration of its diagnosis, care and treatment rendered to the public, more particularly, rendered to the Decedent herein;

hhh. In failing to provide a knowledgeable and skilled medical physician to adequately, appropriately and timely, observe, assess and/or evaluate the Decedent during the course of his terminal disease;

iii. In failing to possess and/or exercise that degree of knowledge, care and skill in the diagnosis, care and treatment of the

Decedent between February 21, 2001 and October 1, 2001; and

iii. In failing to exercise ordinary or even slight care in the management, control and supervision of its business, including its agents, employees and principals.

90. That by reason of one (1) or more acts of negligence, carelessness, willfulness, wantonness, and heedlessness of the Defendants, KENNETH C. KUNZE, M.D.; HILTON HEAD GASTROENTEROLOGY, P.A.; THOMAS P. RZECZYCKI, M.D. HILTON HEAD GENERAL AND LAPAROSCOPIC SURGERY, P.A.; GARY W. THOMAS, M.D. and GARY W. THOMAS, M.D., P.A., as set forth above and as a direct and proximate result thereof, the Plaintiff and/or the Decedent have suffered and will continue to suffer severe economic and non-economic damages as well as personal injury and conscious pain and suffering including but not limited to:

a. Severe and conscious emotional pain and suffering;

b. Severe and conscious physical pain and suffering;

c. Unnecessary and painful medical and surgical tests and procedures, including but not limited to the unnecessary and avoidable March 21, 2001, surgical diversion of the Decedent's colon and the resulting hospitalization;

d. Unnecessary and avoidable hospitalizations;

e. Unnecessary or avoidable cost of surgical, hospital and medical care and treatment;

f. Unnecessary or avoidable costs of surgical and medical supplies;

g. Unnecessary and avoidable impairment of enjoyment of living;

h. Unnecessary and avoidable lost wages; and

i. Other damages

WHEREFORE, as to this First Cause of Action, the Plaintiff, PHYLLIS J. WOGAN, individually and as Personal Representative of the ESTATE OF JAMES JOHN WOGAN, demands judgment against the Defendants, KENNETH C. KUNZE, M.D., HILTON HEAD GASTROENTEROLOGY, P.A.; THOMAS R. RZECZYCKI, M.D.; HILTON HEAD GENERAL AND LAPAROSCOPIC SURGERY, P.A.; GARY W. THOMAS, M.D.; and GARY W. THOMAS, M.D., P.A., in a amount to be determined by the jury, for actual and punitive damages, together with the costs and disbursements.

FOR A SECOND CAUSE OF ACTION AS TO THE DEFENDANTS, KENNETH C. KUNZE, M.D.; HILTON HEAD GASTROENTEROLOGY, P.A.; GARY W. THOMAS, M.D. and GARY W. THOMAS, M.D., P.A.;
(Breach of Third Party Beneficiary Contract)

91. That the Plaintiff repeats, realleges and incorporates each and every allegation contained in Paragraph One (1) through Ninety (90) hereof as if alleged in this Second Cause of Action.

92. That upon information and belief, the Defendants, KUNZE and THOMAS, and the Defendants, HILTON HEAD GASTROENTEROLOGY, P.A. and GARY W. THOMAS, M.D., P.A., are now and were at all times material hereto, physicians and/or health care providers that participated in the Federal Medicare Program; that upon information and belief, such program and its benefits are completely governed, managed and administered by policies, procedures, rules and/or regulations promulgated and enforced by a South Carolina Corporation, namely Palmetto GBA; that upon information and belief and at all times material hereto, there existed a valid and enforceable contract and/or Provider Agreement between the Defendants, KUNZE, THOMAS, HILTON HEAD GASTROENTEROLOGY, P.A., and/or GARY W. THOMAS, M.D., P.A. and Palmetto GBA, which required the Defendants, KUNZE, THOMAS, HILTON HEAD GASTROENTEROLOGY, P.A. and/or GARY W. THOMAS, M.D., P.A., to adhere to all Palmetto GBA rules, regulations, policies, procedures

and requirements, including but not limited to a mandatory claim submission requirement.

93. That at all times material hereto the Decedent, JAMES JOHN WOGAN, was a Medicare eligible beneficiary and was duly enrolled in the Federal Medicare Program Part B and, further, was the rightful and intended third party beneficiary of the above referenced contract between the Defendants, KUNZE, THOMAS, HILTON HEAD GASTROENTEROLOGY, P.A.; and/or GARY W. THOMAS, M.D. and Palmetto GBA.

94. That upon information and belief the Defendants, KUNZE, THOMAS, HILTON HEAD GASTROENTEROLOGY, P.A.; and/or GARY W. THOMAS, M.D., P.A., informed the general public, and more specifically, the Plaintiff and the Decedent herein, that they were active participants in the Federal Medicare Program, that they accepted assignment from Medicare and that they would adhere to all policies, procedures, rules and regulations promulgated and enforced by Palmetto GBA, so that all of their Medicare eligible patients would be able to take full advantage of all possible Medicare benefits, including but not limited to reimbursement for medications covered by Medicare, including but not limited to Sandostatin LAR.

95. That the Defendants, KUNZE, THOMAS, HILTON HEAD GASTROENTEROLOGY, P.A.; and/or GARY W. THOMAS, M.D., P.A., breached the above referenced contract and/or Provider Agreement

on at least four (4) separate occasions when he/they failed to file a Medicare claim.

96. That as a direct and proximate result of the acts and/or omissions of the Defendants amounting to misconduct, and which misconduct is the basis for the Causes of Action set forth herein, the Plaintiff and/or the Decedent have sustained and suffered damages as follows:

a. The Plaintiff is entitled to a refund of the entire amount paid for the above referenced medication.

b. The Plaintiff is entitled to incidental and consequential damages which the Plaintiff has suffered as a result of the Defendants failure and refusal to honor their agreement;

c. The Plaintiffs have been inconvenienced and forced to incur considerable expenses and costs in order to enforce their rights under said contract;

d. The Plaintiff has suffered emotional distress as a result of the problems arising out of the Defendants aforesaid acts and/or omissions; and

e. The Plaintiffs have been damaged in other ways.

WHEREFORE, as to this Second Cause of Action, the Plaintiff, PHYLLIS J. WOGAN, individually and as Personal Representative of the ESTATE OF JAMES JOHN WOGAN, demands judgment

against the Defendants, KENNETH C. KUNZE, M.D., HILTON HEAD GASTROENTEROLOGY, P.A., GARY W. THOMAS, M.D. and GARY W. THOMAS, M.D., P.A., in a amount to be determined by the jury for actual and punitive damages, together with the costs and disbursements, as well as triple damages if the Court and Jury determine that the Defendants conduct constitutes an unfair and deceptive act or trade practice.

FOR A THIRD CAUSE OF ACTION AS TO THE DEFENDANTS, KENNETH C. KUNZE, M.D., HILTON HEAD GASTROENTEROLOGY, P.A.; GARY W. THOMAS M.D. and GARY W. THOMAS, M.D., P.A.;
(Unfair and Deceptive Trade Practices)

97. That the Plaintiff repeats, realleges and incorporates each and every allegation contained in Paragraph One (1) through Ninety Six (96) hereof as if alleged in this Third Cause of Action.

98. That the Plaintiff is informed and believes that the Defendants', KUNZE, THOMAS, HILTON HEAD GASTROENTEROLOGY, P.A., and GARY W. THOMAS M.D., P.A.; aforementioned conduct is injurious to the public interest and to numerous other individual members of the public and has the potential for repetition.

99. That the Plaintiff is informed and believes that the Defendants aforesaid conduct violates the South Carolina Unfair Trade Practices Act, Section

39-5-10, et. Seq., South Carolina Code of Laws, 1976, as amended.

100. That the Plaintiff is informed and believes that she and the ESTATE OF JAMES JOHN WOGAN have sustained and suffered actual, incidental and consequential damages as set forth in Paragraph Ninety Six (96) of her Second Cause of Action and are entitled to triple the actual, incidental and consequential damages together with reasonable attorney's fees and the costs of this action to remedy the violation and to prevent further violations for this Third Cause of Action.

FOR A FOURTH CAUSE OF ACTION AS TO THE DEFENDANTS, KENNETH C. KUNZE, M.D.; HILTON HEAD GASTROENTEROLOGY, P.A.; GARY W. THOMAS, M.D. and GARY W. THOMAS, M.D., P.A.. (Breach of Fiduciary Duty)

101. That the Plaintiff repeats, realleges and incorporates each and every allegation contained in Paragraph One (1) through One Hundred (100) hereof as if alleged in this Fourth Cause of Action.

102. That a special and fiduciary relationship existed by and between the Decedent, JAMES JOHN WOGAN, and the Defendants, KUNZE, THOMAS, HILTON HEAD GASTROENTEROLOGY, P.A., and GARY W. THOMAS, M.D., P.A.

103. That the Decedent, JAMES JOHN WOGAN, placed special confidence and trust in the Defendants, KUNZE, THOMAS, HILTON HEAD GASTROENTEROLOGY, P.A., and GARY W. THOMAS, M.D., P.A., as a result of this relationship.

104. That the Defendants, KUNZE, THOMAS, HILTON HEAD GASTROENTEROLOGY, P.A.; and GARY W. THOMAS, M.D., P.A. had a fiduciary duty to provide appropriate medical treatment and care to the Decedent, JAMES JOHN WOGAN, in his time of need and in a prompt, efficiency, proper, professional, ethical, competent and appropriate manner, specifically the Defendants, KENNETH C. KUNZE, M.D., HILTON HEAD GASTROENTEROLOGY, P.A., GARY W. THOMAS, M.D. and/or GARY W. THOMAS, M.D., P.A. and specifically had an duty to:

a. Promptly purchase the Sandostatin LAR while the Decedent, JAMES JOHN WOGAN, remained under their continuous care and treatment and then promptly submit a Medicare claim, failure to do so constitutes abandonment; or

b. Promptly require the Decedent, JAMES JOHN WOGAN, to sign an Advanced Beneficiary Notice, promptly purchase the Sandostatin LAR Depot and then promptly submit a Medicare claim, failure to do so constitutes abandonment; or

c. Provide the injection via an outpatient procedure; or

d. Answer the pleas from the Decedent and/or the Plaintiff for assistance in alternative means of financing a Thirty Thousand ($30,000.00) Dollar a year medication; or

e. Other duties.

105. That the Decedent, JAMES JOHN WOGAN, placed special trust, confidence and reliance upon the judgment and advisement, if any was provided, of the Defendants, KUNZE, THOMAS, HILTON HEAD GASTROENTEROLOGY, P.A. and GARY W. THOMAS, M.D., P.A.

106. That by the acts and/or omissions of the Defendants, KUNZE, THOMAS, HILTON HEAD GASTROENTEROLOGY, P.A., and GARY W. THOMAS, M.D., P.A., breached their fiduciary duty owed to the Decedent, JAMES JOHN WOGAN, by failing to promptly file reimbursement claims for the above referenced pharmaceutical injections and/or promptly advise the Decedent on other alternatives for financial assistance.

107. That as a direct and proximate result of the acts of the Defendants, KUNZE, THOMAS, HILTON HEAD GASTROENTEROLOGY, P.A. and GARY W. THOMAS, M.D., P.A., the Decedent, suffered conscious and severe mental anguish, pain, suffering and distress, and incurred expense for which the Plaintiff should recover.

WHEREFORE, as to this Fourth Cause of Action, the Plaintiff, PHYLLIS J. WOGAN, individually and

as Personal Representative of the ESTATE OF JAMES JOHN WOGAN, demands judgment against the Defendants, KENNETH C. KUNZE, M.D., HILTON HEAD GASTROENTEROLOGY, P.A., GARY W. THOMAS, M.D. and GARY W. THOMAS, M.D., P.A., in a amount to be determined by the jury for actual and punitive damages, together with the costs and disbursements.

FOR A FIFTH CAUSE OF ACTION AS TO THE DEFENDANTS, KENNETH C. KUNZE, M.D., HILTON HEAD GASTROENTEROLOGY, P.A., THOMAS P. RZECZYCKI, M.D., HILTON HEAD GENERAL AND LAPAROSCOPIC SURGERY, P.A., GARY W. THOMAS, M.D. and GARY W. THOMAS, M.D., P.A.
(Loss of Consortium)

108. That the Plaintiff repeats, realleges and incorporates each and every allegation contained in Paragraph One (1) through One Hundred Seven (107) hereof as if alleged in this Fourth Cause of Action.

109. By reason of the above referenced negligent, reckless and/or intentional acts and omissions of the Defendants and the resulting injuries and damages suffered by the Decedent, JAMES JOHN WOGAN, his wife, the Plaintiff, PHYLLIS J. WOGAN, has suffered and continues to suffer great mental anguish by being forced to witness the suffering endured by her husband, the Decedent, during the last seven (7) months of his life, whereby her own nerves and health have been seriously and permanently

shocked, weakened, and impaired, and by reason of the physical and mental condition of her husband, the Decedent, the Plaintiff, PHYLLIS J. WOGAN, continues to suffer and was denied the care, protection, consideration, companionship, aid and society of her husband, the Decedent.

110. That as a direct and proximate result of the above referenced negligent, reckless and/or intentional act and omissions of the Defendants and the resulting injuries and damages suffered by the Decedent, JAMES JOHN WOGAN, the Plaintiff, PHYLLIS J. WOGAN, has suffered a great and devastating loss of her own in that she lost the love, affection, society, companionship and services of her husband during the last seven (7) months of his life; that she is entitled to appropriate and substantial economic and non-economic damages under the applicable statutes of the State of South Carolina as a result of the loss of her husband as a consortium; and that the Plaintiff has been damaged in other ways.

111. By reason of the foregoing, in the loss of consortium of the husband of the Plaintiff, the Plaintiff, PHYLLIS J. WOGAN, has been damaged.

WHEREFORE, as to this Fifth Cause of Action, the Plaintiff, PHYLLIS J. WOGAN, individually and as Personal Representative of the ESTATE OF JAMES JOHN WOGAN, demands judgment against the Defendants, KENNETH C. KUNZE, M.D., HILTON HEAD GASTROENTEROLOGY, P.A., THOMAS P. RZECZYCKI, M.D., HILTON HEAD GENERAL

AND LAPAROSCOPIC SURGERY, P.A., GARY W. THOMAS, M.D. and GARY W. THOMAS, M.D., P.A. in a amount to be determined by the jury for actual and punitive damages, together with the costs and disbursements.

The Law Office of Duffie Stone LLC

/s/ Isaac M. Stone
Isaac M. Stone, III
7 Plantation Park Drive
P.O. Box 155
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The Law Office of Timothy W. Wogan LLC

/s/ Timothy Wogan
Timothy M. Wogan
P.O. Box 22124
Hilton Head, South Carolina 29925
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Bluffton, South Carolina
February 16, 2004

Program Memorandum Carriers	Department of Health and Human Services (DHHS) HEALTH CARE FINANCING ADMINISTRATION (HCFA)
Transmittal B-01-10	Date: FEBRUARY 9, 2001

CHANGE REQUEST 1553

SUBJECT: Systems Requirements for the Benefits Improvement and Protection Act of 2000 (BIPA) for Drugs and Biologicals Covered by Medicare, Section 114, Mandatory Submission of Assigned Claims for Drugs and Biologicals

This Program Memorandum (PM) addresses requirements in §114 of the BIPA with respect to drugs and biologicals covered by the Medicare program. This PM contains systems changes necessary to implement the policy in CR 1514 which mandated that all drugs and biologicals billed to Medicare must be billed on an assigned basis. This PM is only applicable to drugs and biologicals provided incident to physician or non-physician practitioner's services. A separate PM will follow with instructions for suppliers and DMERCs.

Mandatory Assignment

Under §114 of BIPA, payment for any drug or biological covered under Part B of Medicare may be made

only on an assignment-related basis. Therefore, no charge or bill may be rendered to anyone for these drugs and biologicals for any amount except the Medicare Part B deductible and coinsurance amounts.

Inform physicians and non-physician practitioners in your next bulletin of this provision of the law. Advise them that they must take assignment on claims for drugs and biologicals furnished on or after February 1, 2001. Also advise them that unassigned claims for drugs or biologicals furnished on or after February 1, 2001 will be paid as though they had taken assignment.

Process all claims for drugs and biologicals with a date of service on or after February 1, 2001 as though the physician or non-physician practitioner had taken assignment. If only drugs and biologicals are billed on the claim, and the claim was submitted as unassigned, change the claim to assigned and process as an assigned claim. If a physician or non-physician practitioner submits an unassigned claim that contains both codes for drugs or biologicals and codes for other services, split the claim into two claims. The first claim will be an unassigned claim for services other than drugs or biologicals, and the second will be an assigned claim for drugs or biologicals furnished on or after February 1, 2001.

When a claim for drugs and biologicals was submitted as an unassigned claim and you changed the claim to assigned status (regardless of whether you had to

split the claim), use the following messages to physicians or suppliers and beneficiaries.

Carriers must establish controls to detect and prevent payment for assigned and unassigned claims received for the same service (as well as duplicate assigned or duplicate unassigned claims).

If an appropriate assigned claim is received after an unassigned claim has been paid, carriers do not pay the subsequent claims. Where an enrollee's claim based on an unpaid bill is received and benefits are payable, carriers make payment to him/her unless there is some definite basis for believing that payment has been assigned, e.g., the physician or supplier is a "participating" provider or the bill from a nonparticipating physician or supplier shows that assignment may have been made.

Carriers are instructed to inform physicians that, if they wish to be sure of receiving Part B benefits, they should accept assignment at the time services are furnished and that their submission of claims to the carrier should not be unduly delayed.

30.3.10 – Carrier Submitted Bills by Beneficiary

(Rev. 1, 10-01-03)

B3-3040.1

Carriers do not make payment for non-receipted itemized bills without a Form CMS-1490S claim form signed by either the patient or his/her representative.

Note that CMS does not accept beneficiary submitted claims for items subject to mandatory assignment.

They also do not accept them for blood glucose test strips effective April 1, 2002.

[LOGO] HILTON HEAD MEDICAL GROUP

ONCOLOGY/HEMATOLOGY

Gary W. Thomas, M.D.

Patient: Jim Wogan **Date:** 5-22-01

Patient Phone #: _____ **Time:** 1400 am/pm

Pharmacy Name:

_____

Pharmacy Phone #

_____

work – 842-3747 ext 312

Problem: Phyllis called. She just had a
long talk [with] Geri at Dr. Kunze's office.
They suggested that they call us to
see if we can give the Sandostatin
LAR & bill Medicare for this.
Gastro does not want to buy the
Sandostatin every month & then
wait to get reimbursed for this.
Phyllis is desperate

Response: can't bill for this for our office – not
chemo induced. Gastro only
5-23-01 I spoke [with] Gerri @ Dr. Kunzes office
& told them we cannot give this since it

is not due to chemotherapy I also told
Geri that their office should be able
to order the medication, administer it &
bill for it since it is for the benefit of
the pt is improving his quality of life.

/s/ agree/GT

Gary W. Thomas, M.D., PA

Patient: Jim Wogan **Date:** 4-19-01

Time: 1540 **am/pm**

Patient Phone #: _____ **Pharmacy Name:** CVS Bluffton

Pharmacy Phone #: 815-2805

Problem: could we please refill his
Elavil 25 mg
#90
TPOtid (neuropathic pain)
Pt on Sandostatin QID per Dr. Kunze
want to switch to LAR but Dr. Kunze's office won't order
the drug. They will give it if Phyllis brings it in
≈ $2,000 from the pharmacy

Response: agree/
GT

Gary W. Thomas, M.D.

IN THE COURT OF COMMON PLEAS
STATE OF SOUTH CAROLINA
COUNTY OF BEAUFORT
CIVIL ACTION NO: 02-CP-07-1709

PHYLLIS J. WOGAN, individually and as Personal Representative of the Estate of JAMES JOHN WOGAN,

Plaintiff,

vs.

KENNETH C. KUNZE, M.D., HILTON HEAD GASTROENTEROLOGY, P.A., THOMAS P. RZECZYCKI, M.D., and HILTON HEAD GENERAL AND LAPAROSCOPIC SURGERY, P.A.,

Defendants.

----------/

DEPONENT:	**GERI BURR**
DATE:	December 22nd, 2003
TIME:	2:10 p.m.
LOCATION:	Law Office of Duffie Stone, LLC 7 Plantation Park Drive Bluffton, South Carolina
TAKEN BY:	Counsel for the Plaintiff
REPORTER:	Theresa D. Saxon Certified Professional Reporter and Notary Public Hilton Head, South Carolina

STONE – BURR (DIRECT EXAMINATION)

[2] APPEARANCES OF COUNSEL:

FOR THE PLAINTIFF:

TIMOTHY M. WOGAN, ESQUIRE
and ISAAC M. STONE, ESQUIRE
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7 Plantation Park Drive
Bluffton, South Carolina 29910
843.815.7800

FOR THE DEFENDANT:

JAMES S. GIBSON, JR., ESQUIRE
Howell, Gibson & Hughes, P.A.
25 Rue Du Bois
Beaufort, South Carolina 29907
843.522.2400

ALSO PRESENT:

PHYLLIS J. WOGAN
JILLINDA DELAHUNTY, PARALEGAL

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* * *

STONE – BURR (DIRECT EXAMINATION)

[146] who works for Gary.

Q We'll mark it real quick, and then I'm going to hand you this, and I think that second document I'm handing you, is that Melissa's writing at the top?

A I think it looks like it goes Melissa, and then this looks like Gary's scribble, and then it looks like Melissa, and then this looks like Gary again.

Q And that's that writing at the very bottom of the – whatever that is?

A Because I think that's "GW" there, and I think that's supposed to be "GW" there or "GT." I don't know what that is.

Q Is that the same as this, that's written right after "agrees," is that what we're talking about?

A That's "agrees," yes. The Sandostatin – that says "agree."

Q And that – but that signature right there, is that Thomas's?

A I think that's Dr. Thomas's, because it looks like G something, but I don't know.

Q All right.

[147] A I really don't. But the other part looks like Melissa's, although I don't agree with everything that's in here but . . .

STONE – BURR (DIRECT EXAMINATION)

Q And I guess that's what – that was my question. I wanted to make sure if that's – I know you had said earlier this first document that I handed you, "Dr. Kunze's office won't order the drug, they will give it if Phyllis brings in around $2,000 from" – but that – you don't agree with that statement, is that correct, that that's not information that came –

A Well, because "Patient on Sandostatin," then it says, "QID," that's a symbol for four times a day and he was only on it three times a day.

"Wants to switch to LAR but Dr. Kunze's office won't order the drug" – that's what I'm – I mean, Dr. Kunze ordered it from the pharmacy, so it's not like we wouldn't order it. Dr. Kunze did prescribe it, so of course we had called in the order.

What the last sentence says, "They will give it if Phyllis brings it in," and then, [148] Phyllis says that it's $2,000 from the pharmacy or around $2,000.

And I don't know what he means when he's got "agree," but that looks like Dr. Thomas wrote "agree."

Q The last sentence you agree with, or the . . .

A That we – yeah, if we – we ordered it for her to get from the pharmacy, for us to get, yes.

Q And if she brought it in from the pharmacy, you'd give it to her – you'd give it to him?

A Yes.

STONE – BURR (DIRECT EXAMINATION)

Q Do you think that's Melissa's writing on this document as well, which is the second one I showed you –

A Yes.

Q – other than the scribble which is Dr. Thomas's?

A I think that the more legible writing is Melissa's, and I think the other writing is Dr. Thomas.

Q When it says that "their office," [149] referring to Dr. Kunze's office, "should be able to order the medication, administer and bill for it since it is for the benefit of the patient and is improving his quality of life" –

A I do not remember ever having that conversation with Melissa because out of respect for me and out of respect for her I would have never told her what to do any more than she would have ever told me what to do or – and plus, you're talking about two nurses talking back and forth that can't make a decision anyway.

It wasn't my – her – if it had been her decision, you know, I'm sure that – that she would have said, you know, sure we can give it, because they had it there for them to give.

STONE – BURR (DIRECT EXAMINATION)

I mean, it's not – it's not like there was anybody that was trying to deny care. The only issue here is, you know, who's going to order the medicine and pay for it and wait for reimbursement, because that's what Phyllis wanted done, and the whole problem here is that everybody has been so abused and treated badly by Medicare in that even the injection, the

* * *

STATE OF SOUTH CAROLINA COUNTY OF BEAUFORT	IN THE COURT OF COMMON PLEAS FOURTEENTH JUDICIAL CIRCUIT
PHYLLIS J. WOGAN, individually and as Personal Representative of the ESTATE OF JAMES JOHN WOGAN, Plaintiff, V. KENNETH C. KUNZE, M.D.; HILTON HEAD GASTROENTEROLOGY, P.A.; THOMAS P. RZECZYCKI, M.D.; HILTON HEAD GENERAL, AND LAPAROSCOPIC SURGERY, P.A., GARY W. THOMAS, M.D. and GARY W. THOMAS, M.D., P.A. Defendants.	CASE NO.: 02-CP-07-1709 **AFFIDAVIT OF JUDITH RICHARDSON, MSA, RN, CCS-P (and Exhibits)**

PERSONALLY APPEARED before me, JUDITH RICHARDSON, MSA, RN, CCS-P, who, upon being duly sworn and under oath states as follows:

1. That my name is JUDITH RICHARDSON; that I am over eighteen (18) years old; that I am competent to make this affidavit; and that I am personally familiar with all the testimony that I am about to render.

2. That I graduated from Central Michigan University with a Master of Science in Administration Degree; that I graduate Old Dominion University, Magna Cum Laude, with a Bachelor of Psychology Degree; and that I graduated from Pensacola Junior College with an Associate in Nursing Degree.

3. That between 1986 and 1998 I worked for numerous health care organizations and insurance companies, Health Maintenance Organizations and Preferred Provider Organizations such as, Upjohn Healthcare Services, Blue Cross/Blue Shield of Virginia, Sentara Health Management and Blue Cross/ Blue Shield of North Carolina where I gained extensive experience in private sector insurance and Medicare coding and compliance.

4. That I currently hold the designation, Certified Coding Specialist-Physician (CCS-P), with the American Health Information Association where I have been certified as a specialist in ICD-9-CM and HCPCS Level II coding systems; that these are the medical coding systems used by Medicare and private sector insurance companies; that the CCS-P certification is directed and specific to Medicare and private sector insurance coding systems used in physician based settings such as physician's offices, group physician practices, multi-specialty clinics and specialty centers; and that to obtain this certification I was required to undergo and pass an extensive examination regarding private sector insurance company and Medicare coding and compliance.

5. That for the past six (6) years I have served as a Senior Consultant with Hill and Associates a North Carolina Consulting firm offering Medicare coding and reimbursement education, practice management, billing operations and personnel management services to various major teaching facility physician practices.

6. That as a Senior Consultant with Hill and Associates I have direct responsibility for conducting Medicare evaluation and management audits, conducting Medicare educational seminars and workshops and I facilitate education program's for physicians dealing with Medicare coding and Medicare compliance issues.

7. That I have an extensive background in and I am familiar with Medicare evaluation and management compliance, Medicare coding rules, regulations, policies and procedures, Medicare reimbursement issues, utilization management, medical underwriting, clinical case management and concurrent review of medical care.

8. That based on my knowledge, training, education and experience in Medicare coding and compliance, I am familiar with Medicare rules, regulations, policies, procedures and directives, which interpret the requirements of the Social Security Act of 1965 as they relate to Medicare and the requirements of a Medicare Participating Provider.

9. That based on my knowledge, training, education and experience in physician practice management, particularly as that related to Medicare compliance and Medicare billing practices as well as personnel management, I am familiar with the generally accepted standards of professional physician practice management.

10. That I also currently hold a Professional Registered Nurse's license in North Carolina, Virginia and Florida; and that I have over fifteen (15) years experience as a medical/surgical/ICU Registered Nurse in both community and teaching hospitals varying in range from Two Hundred (200) to Four Hundred and Fifty (450) beds.

11. That based on my knowledge, training, education and experience in nursing, I am familiar the generally accepted standards of nursing care and have an understanding of human anatomy and physiology, the nature of disease processes in humans, and the current methods of diagnosis and treatment of acute and chronic medical conditions and diseases.

12. That I have thoroughly reviewed the medical and hospital records of James John Wogan, pertaining to the medical, surgical and oncological care and treatment he received while he was under the care of Kenneth C. Kunze, M.D.; Thomas P. Rzeczycki, M.D.; Gary W. Thomas, M.D. and others between January 19, 2001 and October 1, 2001 for severe and debilitating diarrhea.

13. That I have thoroughly reviewed the billing records submitted by the Defendants to Medicare and the billing records submitted by the Defendants to the Mr. and Mrs. Wogan.

14. That I have thoroughly reviewed the depositions of Gerri Burr, R.N. and Gary W. Thomas, M.D., along with all the exhibits thereto.

15. That I have reviewed the affidavits of David A. Peura, M.D., F.A.C.G. and Frederick W. Silverman, M.D., F.A.C.S.

16. That I have thoroughly reviewed all phone messages to and from the various parties and nonparties in this matter.

17. That based on my review of the medical records of James John Wogan, my knowledge, education and experience in nursing and my knowledge, education and experience in Medicare coding and Medicare compliance, including compliance with all rules, regulations, policies, procedures and directives of Medicare and based on a reasonable degree of nursing, and Medicare compliance certainty, I intend to render the following Medicare compliance opinion as an expert in Medicare compliance:

(a) That the Local Medical Review Policy (LMRP) relied on by Dr. Kunze and Hilton Head Gastroenterology, P.A. during Dr. Thomas' deposition is not applicable to the facts of this case, as its principal geographic region is Pennsylvania not South Carolina;

(b) Assuming, for the sake of argument, that the above referenced LMRP applied to this case, the mere fact that Mr. Wogan's medical condition may not be listed as an ICD-9 code on the LMRP *does not* mean that Medicare would have considered the medication to be *unnecessary* and thus excluded from coverage. In other words the list of ICD-9 codes on the LMRP is not an exhaustive list of diagnosis, which will support medical necessity;

(c) That, in fact, based on my knowledge, education and experience in nursing, my review of Mr. Wogan's medical records and my understanding of Medicare's rules, regulations, policies, procedures and directives, the Sandsotatin ***LAR*** administered to Mr. Wogan on May 25, 2001; June 22, 2001; July 20, 2001 and August 24, 2001 would, most probably, have been considered "Reasonable and Necessary" by Medicare had a Medicare Claim been submitted by the Defendants or a hospital; and

(d) That based on my knowledge, education and experience in nursing and my understanding of Medicare's rules, regulations, policies, procedures and directives, the Sandostatin ***LAR*** administered to Mr. Wogan on May 25, 2001; June 22, 2001; July 20, 2001 and August 24, 2001 would, most probably, have been a reimbursable "drug or biological" under the

Medicare program. This means that Medicare would have reimbursed a physicians or a hospital for the cost of the medication had they purchased the medication and submitted a Medicare claim;

18. That upon review of pertinent sections of the Social Security Act of 1965 and the policies, procedures, rules, regulations and directives of the United States Department of Health and Human Services/Center for Medicare Services interpreting the requirements under the Act, James John Wogan's medical and surgical records, the depositions of Gerri Burr, R.N. and Gary W. Thomas, M.D., the telephone records and the Affidavit of Phyllis J. Wogan, and based on my knowledge, education and experience in Medicare coding and compliance, in my opinion, Kenneth C. Kunze, M.D.; Hilton Head Gastroenterology, P.A.; Gary W. Thomas, M.D.; and Gary W. Thomas, M.D., P.A. violated at least two (2) Medicare policies, procedures, rules, regulations, and directives interpreting the Act on numerous occasions, including but not limited to the following:

AS TO MEDICARE'S MANDATORY CLAIM SUBMISSION POLICY

(a) That between May, 2001 and September 2001, Kenneth C. Kunze, M.D.; Hilton Head Gastroenterology, P.A.; Gary W. Thomas, M.D. and Gary W. Thomas, M.D., P.A. violated Medicare's Mandatory Claim Submission Policy, namely

that if a beneficiary or his/her representative believes a supply or service may be covered by Medicare or desires a formal Medicare determination for consideration by a supplemental insurance, the provider *must* submit a claim. *This policy is attached hereto and incorporated herein as Exhibit "A;"*

(b) That pursuant to Exhibit "A," Kenneth Kunze, M.D.; Hilton Head Gastroenterology, P.A.; Gary W. Thomas, M.D. and/or Gary W. Thomas, M.D., P.A., as Medicare Participating Providers, had an obligation and requirement, once requested to do so by Mr. Wogan or someone acting on his behalf, to purchase the Sandostatin ***LAR***, have the Decedent complete an Advanced Beneficiary Notice and submit a Medicare claim for the cost of the medication;

(c) That by failing to submit the claim, as requested by Mr. Wogan or someone acting on his behalf, Kenneth C. Kunze, M.D.; Hilton Head Gastroenterology, P.A.; Gary W. Thomas, M.D. and Gary W. Thomas, M.D., P.A. violated Section 1848(g)(4) of the Social Security Act, as outlined and explained in Exhibit "A," on at least four (4) separate occasions;

AS TO MEDICARE'S PROHIBITION AGAINST "BALANCE BILLING"

(a) That between November 3, 2002 and December 12, 2003, Kenneth C. Kunze, M.D. and Hilton Head Gastroenterology, P.A. repeatedly attempted to "balance bill" Mr. Wogan, a Medicare Beneficiary, in the amount of $11.76. These attempts by Kenneth C. Kunze, M.D. and Hilton Head Gastroenterology, P.A. came after Medicare had specifically advised him/it that such attempts to bill and collect this amount were *prohibited*.

(b) That between November, 2002 and December 2003, Kenneth C. Kunze, M.D.'s and/or Hilton Head Gastroenterology, P.A.'s collection manager repeatedly sent bills to Mrs. Wogan for the above referenced $11.76 and on at least one occasion threatened to place a lien on Mrs. Wogan's property and/or report Mr. Wogan, who had been deceased for more than a year at the time of the bill, to national credit reporting agency for the "outstanding amount"; and

(c) That each attempt by Kenneth C. Kunze, M.D. and/or Hilton Head Gastroenterology, P.A. to bill for this amount are separate violations of the Social Security Act of 1965 and his/its Participating Provider Agreement with The United States Health Care Financing Administration

(HCFA), *which is attached hereto and incorporate herein as Exhibit "B"*

19. That by refusing to submit a Medicare claim for the medication at issue in this matter, Kenneth C. Kunze, M.D.; Hilton Head Gastroenterology, P.A.; Gary W. Thomas, M.D.; and Gary W. Thomas, M.D., P.A. prevented and deprived Mr. Wogan from taking full advantage of his Medicare rights and benefits in violation of The Social Security Act of 1965 and Medicare rules, regulations, policies and procedures interpreting the requirements of a Participating Provider under that Act.

20. Furthermore, that it is my opinion, that the violations of Medicare's rules, regulations, policies and procedures by the Defendants, as set forth above, caused and/or contributed to unnecessary emotional and mental pain and suffering as well as economic loss during the last seven months of Mr. Wogan's life.

21. Finally, that it is my opinion, to a reasonable degree of physician practice management certainty, and based on my education, experience, training and knowledge in physician practice management, physician billing operations and personnel management that Hilton Head Gastroenterology, P.A., a physician practice that accepts Medicare patients and a physician practice that is a Medicare Participating Provider, was negligent in its practice management, billing operations and personal management, most particularly as those operations and

management duties impact compliance with all Medicare rules, regulations, policies and procedures.

22. That upon further review of any additional information, including further medical billing documents and the depositions of the office/billing manager of Gary W. Thomas, M.D., P.A., I may supplement my opinions and this affidavit.

/s/ Judith C. Richardson, MSA, RN, CCS-P
Judith Richardson, MSA, RN, CCS-P
FEDL R263-423-45-801-0

Subscribed and Sworn to before me

This the 18 day of June, 2004

/s/ Christine H. Sanders
NOTARY PUBLIC STATE OF North Carolina
My Commission Expires 8/19/2006

EXHIBIT A

Palmetto GBA

Part B Carrier

South Carolina
Advisories
1996-1997

Mandatory Claim Submission

NOTE: If you enter into a private contract, this article does not apply to you.

Section 1848(g)(4) of the Social Security Act requires physicians and suppliers to submit claims for covered services. The Health Care Financing Administration (HCFA) policy for filing Medicare Part B claims is stated below:

- All claims for covered services rendered to Medicare beneficiaries must be submitted to the Medicare Carrier.

- The claims filing requirement applies to all physicians and suppliers who provide services to Medicare beneficiaries.

- Physicians and suppliers are not required to take assignment of Medicare benefits unless they are enrolled in the Medicare participating physician and supplier program, or the Medicare beneficiary is a recipient of a state medical assistance (Medicaid).

- Physicians and suppliers may not charge the beneficiary for preparing and the filing the Medicare claim. Physicians and suppliers are responsible for mailing the claim form. They may not ask Medicare

beneficiaries to assume the responsibility to file Medicare claims.

♦ Medicare assigned claims must be filed within one year from the service date or payment will be reduced by 10%.

♦ Patients should be informed that a claim will be completed and filed on their behalf. If the patient is given a copy of the claim, the following statement (or one similar) should be documented in the claim: "Do not use this bill for claiming Medicare benefits. A claim will be submitted to Medicare on your behalf by this office."

♦ Providers are not required to submit claims for the following services:

-Used DME purchased from a private source

-Third party biller claims

-Foreign claims

-Medicare Secondary payer (MSP) claims, when a provider does not possess information necessary for filing an MSP claim.

If the provider does possess the essential information needed to file a claim, mandatory claim submission requirements apply.

As a reminder, providers are responsible for obtaining and updating the address and insurance information for their patients.

Exception:

As a rule, providers are not required to submit claims for non-covered services. However, if the beneficiary or his/her representative believes a service may be covered or desires a formal Medicare determination for consideration by a supplemental insurance, the provider must submit a claim. The claim should indicate the service is non-covered but is being submitted at the beneficiary's insistence.

Timely Filing of Claims

Generally, claims must be filed within the qualifying time limits to be eligible for Medicare consideration. Claims must the submitted by the end of the calendar year following the year in which the services were rendered. Services provided during the last three months of a calendar year are, for purposes of this rule, considered provided in the calendar year. Below are examples of the time limits.

Service Dates:

October 1, 1995 – September 30, 1996 ***Claim Must Be Filed By:*** December 31, 1997

Service Dates:

October 1, 1996 – September 30, 1997 ***Claim Must Be Filed By:*** December 31, 1998

Service Dates:

October 1, 1997 – September 30, 1998 ***Claim Must Be Filed By:*** December 31, 1999

As a reminder, there is a 10% reduction in the Medicare payment for untimely claim submissions.

Providers are prohibited from billing beneficiaries for the penalty payment reduction that is applied to assigned claims filed more than twelve (12) months after the date of service. Providers may only charge the beneficiary for the remaining annual deductible, co-insurance, and/or for non-covered services. Since the late claim filing penalty does not fall within one of these categories, Medicare providers cannot bill the beneficiary for the 10% payment reduction.

Monitoring of Violators

The Medicare Anti-Fraud Unit monitors physicians and suppliers to ensure compliance with the Medicare mandatory claim filing requirements. Physicians and suppliers who do not submit claims for beneficiaries, who charge for preparing and filing claims, and/or who charge the beneficiary the 10% reduction in the Medicare payment for untimely claim submissions may be subject to civil monetary penalties of up to $10,000 per violation.

December 1997 Medicare Advisory
. . . . 1998 Clinical Laboratory Fee Schedule
. . . . 1998 Deleted Codes
. . . . Area Code Changes and the HCFA-855 C
. . . . Ceftriaxone (Rocephin) Correction
. . . . Changes in Medicare for 1998
. . . . CLIA Test Codes
. . . . Coding for Q0091
. . . . Date Fields for HCFA-1500
. . . . Electrostimulation for Wound Healing

. . . . Excluded Provider
. . . . E/M Claims Review
. . . . E/M Codes for Nursing Care
. . . . Faxed Appeals Not Accepted
. . . . Fee Schedule for Clinical Psychologists and Clinical Social Workers
. . . . Foot Care Modifiers
. . . . I've Got A Question . . . " Mailbag
. . . . Interest Rate Update
. . . . Mandatory Claim Submission
. . . . Medical Documentation Needed
. . . . Medicare's Top Ten List
. . . . Medicare Participation Program
. . . . Medicare Transaction System
. . . . Not Otherwise Classified (NOC) Codes
. . . . Overpayment Procedures
. . . . Paclitaxel (Taxol) J9265
. . . . Physician Orders for Home Health Care
. . . . Using the ARU to Check Entitlement
. . . . Visco-Supplementation

EXHIBIT B

MEDICARE

Participating Physician/Supplier Agreement
For New Providers Beginning Participation
after January 1, 1999

Name(s) and Addresses Of Participant* (Please Type or Print)	Physician or Supplier Identification Code(s)*
Kenneth C. Kunze	D17563
25 Hospital Circle Blvd 56367	
Hilton Head SC 29926	

The above-named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. **Meaning of Assignment** – For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare Program. Under an assignment, the approved charge, determined by the Medicare carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.

2. **Effective Date** – If the participant files the agreement with any Medicare carrier during the

enrollment period, the agreement becomes effective on the date the carrier receives the agreement.

3. **Term and Termination of Agreement** – This agreement shall continue in effect through December 31 following the date the agreement becomes effective and shall become and shall be renewed automatically for each 12-month period January 1, through December 31 thereafter unless one of the following occurs:

   a. During the enrollment period provided near the end of any calendar year, the participant notifies in writing every Medicare carrier with whom the participant has filed the agreement or a copy of the agreement that the participant wishes to terminate the agreement at the end of the current term. In the event such notification is mailed or delivered during the enrollment period provided near the end of any calendar year; the agreement shall end on December 31 of that year.

   b. The Health Care Financing Administration may find, after notice to and opportunity for a hearing for the participant, that the participant has substantially failed to comply with the agreement. In the event such a finding is made, the Health Care Financing Administration will notify the participant in writing that the agreement will be terminated at a time designated in the notice. Civil and criminal penalties may also be imposed for violation of the agreement.

*List all names and identification codes under which the participant files claims with the carrier with whom this agreement is being filed.

/s/ [Illegible]	President
SIGNATURE OF PARTICIPANT (or authorized representative of participating organization)	[Illegible] is authorized representative of organization
843-651 6668	9/19/2000
AREA CODE Office Telephone Number	Date

FOR CARRIER ONLY
Received by Carrier:

Effective Date: ____ Initials of Carrier Official: ____

STATE OF SOUTH CAROLINA COUNTY OF BEAUFORT	IN THE COURT OF COMMON PLEAS FOURTEENTH JUDICIAL CIRCUIT
PHYLLIS J. WOGAN, individually and as Personal Representative of the ESTATE OF JAMES JOHN WOGAN, Plaintiff, V. KENNETH C. KUNZE, M.D.; HILTON HEAD GASTROENTEROLOGY, P.A.; THOMAS P. RZECZYCKI, M.D.; HILTON HEAD GENERAL, AND LAPAROSCOPIC SURGERY, P.A., GARY W. THOMAS, M.D. and GARY W. THOMAS, M.D., P.A. Defendants.	CASE NO.: 02-CP-07-1709 **AFFIDAVIT OF DAVID A. PEURA, M.D., F.A.C.P., F.A.C.G.**

PERSONALLY, appeared before me, DAVID A. PEURA, M.D., who, upon being duly sworn and under oath states as follows:

1. That I received my medical degree from the University of Vermont Medical School in 1971.

2. That successfully completed my medical internship at the Letterman Army Medical Center, San Francisco, California, in 1972.

3. That I successfully completed my medical residency at the Letterman Army Medical Center, San Francisco, California, in 1975, where I served as Chief Resident in Medicine from 1974 to 1975.

4. That I successfully completed my medical fellowship in Gastroenterology at Walter Reed Army Medical Center, Washington, D.C. in 1977.

5. That I retired from the United States Army in 1990 with the rank of Colonel.

6. That I am board certified by the American Board of Internal Medicine and the American Board of Internal Medicine subspecialty Boards in Gastroenterology.

7. That I am currently licensed physician in the State of Virginia.

8. That I am currently the Associate Chief of Gastroenterology and Hepatology at the University of Virginia Health Sciences Center, Charlottesville, Virginia, where I actively treat patients with digestive disorders and diseases and where I serve on the Department of Medicine's Clinical Competence Committee.

9. That I have over twenty years of teaching experience in the field of gastroenteroloy and currently serve as Professor of Medicine in the Division of Gastroenteroloy and Hepatology at the University of Virginia Health Sciences Center.

10. That I currently serve on numerous national committees of the American Gastroenterological Association.

11. That I am currently a Fellow in the American College of Physicians, the American College of Gastroenterology and a member of the American Society of Gastrointestinal Endoscopy, the American Gastroenterological Association and the Virginia Gastroenterological Society.

12. That I have received editorial appointments to and have authored abstracts, publications and chapters for numerous national professional journals including the American Journal of Gastroenterology, the American Journal of Medicine, the Annals of Internal Medicine, Digestive Diseases and Sciences, Gastroenterology, Gastrointestinal Endoscopy and the New England Journal of Medicine.

13. That I have thoroughly reviewed the medical and hospital records of James John Wogan, pertaining to the medical and surgical care and treatment he receive while he was under the care and treatment of Kenneth C. Kunze, M.D.; Thomas P. Rzeczycki, M.D.; Gary W. Thomas, M.D. and others between January 19, 2001 and October 1, 2001 for rectal cancer and high output/high frequency diarrhea.

14. That based on my knowledge, training, education and experience in medicine and more particularly, in the fields of internal medicine and gastroenterology, I am familiar with the generally

accepted standards of medical, internal medicine and gastrointestinal care, treatment and practice as it relates to the diagnosis, care and treatment of patients who suffer various forms of gastrointestinal disorders, including, acute and chronic diarrhea, malnutrition, small bowel injury, gastrointestinal cancers, gastrointestinal bacterial infestation and fistulae.

15. That based on my review of the medical records of James John Wogan, my knowledge, education and experience in medicine and more particularly in the fields of internal medicine and gastroenterology and based on a reasonable degree of medical certainty, I intend to render the following medical, internal medicine and/or gastroenterological opinions as an expert in the field of gastroenterology.

16. In my opinion, Kenneth C. Kunze, M.D. departed from generally accepted medical standards of gastroenterological care and treatment by in the following particulars:

a. Between February 22, 2001, and March 21, 2001, in failing to obtain a complete, thorough and accurate medical history of James Wogan's medical condition, and if obtained, in failing to appreciate his medical history, which was highly indicative of a small bowel injury or fistula formation;

b. Between February 22, 2001 and March 21, 2001, in failing to fully consider and

appreciate the medical signs and symptoms then and there presented by James Wogan, which were highly indicative of small bowel injury or fistula formation;

c. Between February 22, 2001 and March 21, 2001, in failing to perform or to have performed appropriate diagnostic tests on James Wogan, including but not limited to a barium enema and/or gastrografin enema, water soluble enema and/or a small bowel X-ray, one or more of which were indicated, given Mr. Wogan's history and presenting signs and symptoms, and would have most probability detected Mr. Wogan's fistula prior to the surgical diversion of his colon;

d. Between February 22, 2001 and March 21, 2001, in failing to make a correct diagnosis of James Wogan's medical condition, specifically in failing to diagnose a small bowel-rectal fistula, so as to prevent and/or avoid further unnecessary surgical procedures and hospitalizations;

e. In failing to provide appropriate gastroenterological care and treatment to Mr. Wogan between February 22, 2001 and March 31, 2001;

f. In failing to reassess James Wogan's diagnosis, care and/or treatment periodically between February 22, 2001 and March 21, 2002 in sufficient time to

prevent and/or avoid unnecessary surgical procedures and hospitalizations;

g. Between February 22, 2001 and March 11, 2001, in failing to realize and/or appreciate James Wogan's impending nutritional crisis and, further, failing to accept and follow the March 6, 2001 recommendations of a nutritional consultant who recommended that he seriously consider TPN/PPN to address James Wogan's severe nutritional risk;

[No subparagraph h. in original.]

i. Between March 5, 2001 and March 21, 2001, in negligently failing to order any appropriate diagnostic test to eliminate and/or support his differential diagnosis of radiation injury to the small bowel, including small bowel studies, barium enemas, water soluble enemas, small bowel x-rays and/or qualitative fat studies, all of which most probably would have shown small bowel injury and/or fistula formation;

j. On March 6, 2001, in failing to appreciate the significant endoscopic finding of an Aulcerated area@ in Mr. Wogan's colon and, further, failing to order appropriate diagnostic testing to further delineate and define the ulcerated area and determine if it was a fistula;

k. On March 19, 2001, in negligently referring James Wogan to a surgeon for surgical diversion of his colon when he

knew or should have known, in the exercise of reasonable care, that such procedure was not indicated and would not resolve James Wogan's severe and debilitating diarrhea as it was most probably caused by a fistula and not from an obstructive process;

l. In failing to consider and attempt less aggressive and invasive means of controlling James Wogan's severe and debilitating diarrhea prior to ordering extensive abdominal surgery and permanent diversion of James Wogan's colon;

m. Between April 1, 2001 and October 1, 2001, in breaching his fiduciary duty by failing to assist, or at the very least, respond to Mr. and Mrs. Wogan in their repeated requests for assistance in filing a Medicare claim or to find alternative forms of possible financial assistance such as an outpatient procedure; and

n. Other deviations from the standard of care.

17. Furthermore it is my opinion, based on a reasonable degree of medical certainty, that the deviations from the generally accepted medical and/or gastroenterological standards, as set forth above, caused and/or contributed to unnecessary physical and emotional pain and suffering during the last seven months of Mr. Wogan's life.

18. Furthermore, it is my opinion that as Medicare Participating Providers the Defendant physicians had an obligation and duty to adhere to all applicable Medicare policies, procedures, rules and regulations.

19. Finally, it is my opinion, to a reasonable degree of medical, internal medicine and gastroenterological certainty that the Sandostatin, which was administered to Mr. Wogan between April 1, 2001 and October 1, 2001, was reasonable and necessary for his medical condition and is what stopped his prolonged course of high output/high frequency diarrhea.

20. That upon review of any additional information I may supplement my opinion and this affidavit.

/s/ David A. Peura
David A. Peura, M.D., F.A.C.P., F.A.C.G.

Subscribed and Sworn to before me

This the 15th day of June, 2004

/s/ George Webber
NOTARY PUBLIC STATE OF Virginia
My Commission Expires 12/31/05

19 (2)

No. 08-869

IN THE
SUPREME COURT OF THE UNITED STATES

PHYLLIS J. WOGAN, INDIVIUALLY AND AS PERSONAL REPRESENTATIVE OF THE ESTATE OF JAMES JOHN WOGAN

Petitioner,

v.

KENNETH C. KUNZE, M.D. AND HILTON HEAD GASTROENTEROLOGY, P.A.,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE SOUTH CAROLINA SUPREME COURT

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

Andrew F. Lindemann - Counsel of Record
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Counsel for Respondents

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STATEMENT OF THE CASE

The Petitioner, Phyllis J. Wogan, individually and as Personal Representative of the Estate of James John Wogan, brought this action alleging only state law causes of action against the Respondents Kenneth C. Kunze, M.D. and his medical practice, Hilton Head Gastroenterology, P.A., in addition to other defendants.

The Petitioner's husband, James J. Wogan, was diagnosed in 1997 with rectal cancer. At that time, he began chemotherapy treatment with Gary Thomas, M.D., an oncologist. Mr. Wogan developed a severe case of diarrhea resulting in malnutrition and dehydration, for which he was referred to Dr. Kunze, a gastroenterologist. Dr. Kunze performed a colostomy in order to stop the diarrhea; however, the procedure did not remedy the problem. Dr. Kunze placed Mr. Wogan on the drug Sandostatin SC which was inserted subcutaneously three times a day and was not covered by Medicare.

After determining that the drug was effective at controlling the diarrhea, Dr. Kunze informed the Wogans that he would change the medication to Sandostatin LAR, a long acting form of the medication which could be administered monthly. The Petitioner alleges that the Sandostatin LAR is covered by Medicare although that factual question is disputed. She further alleges that Dr. Kunze originally indicated he would pre-order the Sandostatin LAR, administer it in his office, and submit the claim to Medicare.

According to the Petitioner, Dr. Kunze later refused to pre-order the Sandostatin LAR and administer it in his office because he did not believe that it was covered by Medicare unless the diarrhea was caused by the chemotherapy. The Petitioner consulted with Dr. Thomas to determine whether

he would prescribe and administer the medication, but he declined. Dr. Thomas was of the opinion that the diarrhea was not caused by the chemotherapy and would not be covered by Medicare. Dr. Kunze ultimately agreed to administer the Sandostatin LAR in his office, but he required the Wogans to purchase the monthly dose directly from the pharmacy.

The Wogans purchased the Sandostatin LAR at a cost of approximately $2,000 for three months. Neither Dr. Kunze or Dr. Thomas would assist the Wogans with filing a Medicare claim. Mr. Wogan subsequently died in October 2001.

The Petitioner filed this state court action alleging that Dr. Kunze and his practice were negligent in failing to file Medicare claims for the Sandostatin LAR. She also alleged that Dr. Kunze breached his contract with Medicare and that Wogan was a third-party beneficiary to that contract. Finally, she alleged claims for breach of fiduciary duty, a violation of the South Carolina Unfair Trade Practices Act (UTPA), and loss of consortium.

The trial court granted partial summary judgment to Dr. Kunze and his medical practice, finding that the Medicare Act did not provide for a private right of action. On appeal, the South Carolina Court of Appeals affirmed the lower court. *See, Wogan v. Kunze*, 366 S.C. 583, 623 S.E.2d 107 (Ct. App. 2005). The South Carolina Supreme Court granted certiorari. In her petition to that court, the Petitioner abandoned her breach of contract and UTPA claims.

The South Carolina Supreme Court affirmed the summary judgment as modified. The court concluded that "there are some circumstances in which a state law negligence claim may be maintained against a third party as a result of the denial of Medicare benefits." *Wogan v. Kunze*, 379 S.C. 581, 666 S.E.2d 901, 904 (2008). The court

explained that "whether a state common law action for negligence may be maintained depends ... on whether or not the plaintiff's claims are, at bottom, a claim seeking payment of reimbursement of sums which are alleged to be covered by Medicare, or whether the claims are wholly independent, but nonetheless stemming from the failure to provide some type of Medicare service." 666 S.E.2d at 905. The court affirmed the summary judgment for Respondents because "it is, at bottom, a claim for reimbursement of the $2000 per month which was expended on Sandostatin LAR prior to Mr. Wogan's death." *Id.* The court reached the same result with respect to the breach of fiduciary duty claim.

Importantly, the Petitioner did not raise any federal constitutional claims in seeking a writ of certiorari from the South Carolina Supreme Court. No constitutional claims are pled in the Petitioner's amended complaint. (App. 68-107). Further, the Petitioner did not raise any due process or equal protection claims or arguments to the South Carolina Supreme Court until after that court issued its decision. The due process and equal protections arguments were made for the first time in a petition for rehearing which was summarily denied.

REASONS FOR DENYING THE PETITION

I. Introduction

The Petitioner has abandoned her state law claims with the exception of her negligence and breach of fiduciary duty claims. She alleges that the Respondent Kenneth Kunze, M.D. breached both the standard of care for medical practitioners and a fiduciary duty in failing to submit Medicare claims for Sandostatin LAR totaling approximately $6,000.00. She insists incorrectly that Medicare regulations prohibited her husband from submitting his own claims to Medicare to recover the costs of the medication if indeed the medication were covered by Medicare, which is an issue of fact in dispute.

The Petitioner concludes that the South Carolina Supreme Court affirmed the dismissal of her state law claims on the basis of preemption. She has therefore presented three questions for consideration of this Court, none of which were presented to the lower courts.

II. South Carolina Supreme Court Did Not Expand the Scope of Medicare Act Preemption.

The Petitioner alleges that the South Carolina Supreme Court improperly expanded the scope of Medicare Act preemption. She insists that the South Carolina Supreme Court analyzed the case under the "jurisdictional provisions" of 42 U.S.C. § 405(h) rather than the "preemptive provisions" of that statute.

To fully understand the scope of the decision of the South Carolina Supreme Court, it is necessary to review the decision that was under review by that court. In the South Carolina Court of Appeals, that intermediate appellate court

examined through a detailed analysis whether there is an express or implied right of action under the Medicare Act, 42 U.S.C. § 1395. That court concluded that "there is no right of action, either express or implied, relating to the failure of a physician to file a claim under 42 U.S.C. § 1395w-4(g)(4)(A)." *Wogan v. Kunze*, 366 S.C. 583, 623 S.E.2d 107, 112 (Ct. App. 2005). That court indeed noted that the Petitioner "concedes there is no *express* provision in the Act allowing her to sue the physicians for failing to file a claim. The Act provides for penalties and sanctions, but no private action." 623 S.E.2d at 113. Ultimately, the South Carolina Court of Appeals observed that the Petitioner "is asserting an action for violation of the Medicare Act under the rubric of a state law claim" and ruled that the Petitioner could not base her state law claims on a failure to file a Medicare claim. 623 S.E.2d at 117. The court found that the state law claims "were an attempt to create a private cause of action where none exists." 623 S.E.2d at 122.

In reviewing the Court of Appeals' decision, the South Carolina Supreme Court recognized that "Wogan does not contest the fact that case law generally holds there is no private right or action under the Medicare Act." *Wogan v. Kunze*, 379 S.C. 581, 666 S.E.2d 901, 904, n.5 (2008). The court further agreed with the ultimate ruling of the South Carolina Court of Appeals but found that the holding was "overly broad." 666 S.E.2d at 904. The court recognized that "there are some circumstances in which a state law negligence claim may be maintained against a third party as a result of the denial of Medicare benefits." *Id.*

Importantly, the Petitioner does not dispute here that the Medicare Act did not create a private right of action. In the lower courts, she simply maintained that the breach of a duty under the Medicare Act should serve as the basis for a state law negligence action. The South Carolina Supreme Court agreed except in those cases where those claims are "at bottom a claim seeking reimbursement of sums which are

alleged to be covered by Medicare." *Wogan*, 666 S.E.2d at 905.

In drawing the distinction between what violations of the Medicare Act may be the subject of a state law tort claim under South Carolina law and which claims may not, the South Carolina Supreme Court cited to this Court's decision in *Heckler v. Ringer*, 466 U.S. 602 (1984). In that case, this Court explained that the petitioners' claims were "at bottom" claims seeking payment for their surgery. This Court held that claims that are "inextricably intertwined" with a claim for Medicare benefits may not be judicially pursued until all levels of administrative remedies are exhausted. 466 U.S. at 614. However, *Heckler* does not require exhaustion of administrative remedies for those claims that are not "inextricably intertwined" with but rather "wholly collateral" to the denial of benefits. 466 U.S. at 618. Thus, relying on *Heckler*, the South Carolina Supreme Court has applied that same distinction to South Carolina common law. If a state claim is "inextricably intertwined" with a claim for benefits and the remedy is the recovery of the Medicare benefits, then there is no state law right of recovery. The South Carolina Supreme Court found that the Petitioner's "claim is therefore 'inextricably intertwined' with the refusal to file a Medicare claim and is therefore not cognizable on state law negligence grounds." *Wogan*, 666 S.E.2d at 905.

The South Carolina Supreme Court's decision is not at odds with this Court's decision in *Heckler* nor any existing federal case law. The South Carolina Supreme Court's decision was not necessarily premised on federal preemption or even on the concept of exhaustion of administrative remedies. The decision, in effect, borrowed the rule from *Heckler* to limit the scope of the state common law. The court recognized that there may be negligence claims under South Carolina law that may be premised on the violation of the Medicare Act. The court in fact explained that a "[v]iolation of a Medicare statute could conceivably be used

to support a state negligence claim where the state law claim is not inextricably intertwined with a claim for Medicare reimbursement." *Wogan*, 666 S.E.2d at 905, n.6. However, if the negligence claim is a claim seeking the recovery of Medicare benefits, then such a claim was "not cognizable on state law negligence grounds." *Wogan*, 666 S.E.2d at 905.

Nonetheless, even if the decision of the South Carolina Supreme Court may be construed as relying strictly on federal preemption and mandatory exhaustion of administrative remedies, there is no error. Section 405(h) provides:

> The findings and decision of the [Secretary] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or government agency except as herein provided. No action against [the Secretary] shall be brought under section 1331 or 1346 or Title 28 to recover on any claim arising under this subchapter.

42 U.S.C. § 405(h). The first two sentences of § 405(h) require administrative exhaustion. Because the Petitioner's claim is premised on the reimbursement or payment of Medicare benefits as a remedy, all levels of administrative review must first be exhausted. That is particularly true given that the Petitioner's state law claims require a coverage determination, i.e., whether the Sandostatin LAR was even covered under Medicare.[1] Clearly, the Petitioner is

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[1] The Petitioner maintains that "there is no doubt" that the cost of the medication would have been covered by Medicare. That is incorrect. It is disputed in this case whether the Sandostatin LAR was even covered by Medicare. Dr. Gary Thomas testified that the Sandostatin LAR was not covered by Medicare because the diarrhea was not caused by the chemotherapy.

precluded from pursuing her state law claims when she has failed to initially exhaust her administrative remedies.

Moreover, the provisions of § 405(h) operate in tandem. The third sentence of § 405(h) provides that "§ 406(g), to the exclusion of 28 U.S.C. § 1331, is the sole avenue for judicial review for all 'claims arising under' the Medicare Act." *Heckler*, 466 U.S. at 615. Therefore, once administrative remedies are exhausted, a Medicare beneficiary may seek judicial review; yet, in accordance with 42 U.S.C. § 405(g), the review must be brought in a district court of the United States. *See, Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000) ("Section 405(h) purports to make exclusive the judicial review method set forth in § 405(g)"). Judicial review may not be sought by pursuing a state law tort claim in state court.

In sum, the South Carolina Supreme Court, as did the South Carolina Court of Appeals, did not necessarily decide this case on the basis of preemption or exclusive federal jurisdiction or even exhaustion of administrative remedies. Instead, the courts applied the principle that there is not an express or implied right of action under the Medicare Act for the failure of a physician to file a claim and concluded that no such private right of action exists under state common law as well. It is the prerogative of the South Carolina appellate courts to set the parameters of state common law, and this Court has no jurisdiction to review or reverse a state's determination of its common law.

Nonetheless, even if the decision of the South Carolina Supreme Court is read as applying federal preemption and mandatory exhaustion of administrative remedies under the Medicare Act, the court was correct in holding that a claim that seeks the recovery of Medicare benefits as a remedy and is "inextricably intertwined" with a claim for benefits may not be the subject of a state law tort claim or breach of fiduciary claim. There is no dispute that the Petitioner is

seeking in the present case the recovery of approximately $6,000 which was paid for three prescriptions of Sandostatin LAR. The state law claims are inextricably intertwined with a Medicare claim as evidenced by the fact that a determinative issue will be whether Medicare even covered the Sandostatin LAR. Consequently, the South Carolina Supreme Court ruled correctly that the Petitioner could not pursue the reimbursement or payment of Medicare benefits as damages by means of a state law claim.

III. Petitioner's Due Process and Equal Protection Arguments are Not Preserved and are Erroneously Premised on the Notion that a Medicare Beneficiary Cannot File His Own Claim.

The Petitioner has also raised due process and equal protection arguments in her petition. Those arguments were not raised at the trial level and, in fact, were raised for the first time only in a petition for rehearing to the South Carolina Supreme Court.

South Carolina appellate law clearly provides that a party may not raise an issue for the first time in a petition for rehearing. The South Carolina appellate courts routinely reject attempts to raise new issues or arguments in a petition for rehearing. For instance, in *Kennedy v. South Carolina Retirement System*, 349 S.C. 531, 564 S.E.2d 322 (2001), the South Carolina Supreme Court explained that "[t]he purpose of a petition for rehearing is not to present points which lawyers for the losing parties have overlooked or misapprehended, nor is it the purpose of the petition for rehearing to have the case tried in the appellate court a second time." 564 S.E.2d at 322. *See also, Kleckley v. Northwestern National Cas. Co.*, 338 S.C. 131, 526 S.E.2d 218 (2000) (issue raised for first time in petition for rehearing not preserved for review); *Liberty Loan Corp. of Darlington v. Mumford*, 283 S.C. 134, 322 S.E.2d 17 (Ct. App. 1984) (same).

Nonetheless, even if this Court were to consider these constitutional claims that were not timely raised below, the Petitioner's position is flawed. The Petitioner's argument is based on the erroneous position that a Medicare beneficiary is barred from filing his own Medicare claim for reimbursement of the costs of a covered medication. In making this argument, the Petitioner cites only to 42 C.F.R. § 414.707(b) which provides: "Effective with services furnished on or after February 1, 2001, payment for any drug covered under Part B of Medicare may be made on an assignment-related basis only." 42 C.F.R. § 414.707(b). This regulation controls only the basis for *calculating* the payment amount. It does not restrict, as the Petitioner suggests, who may seek Medicare reimbursement. It does not prohibit a Medicare beneficiary from filing his own claim for reimbursement. In fact, the Medicare Program Memorandum (App. 118) supports this very point. The Program Memorandum provides:

> Under § 114 of BIPA, payment for any drug or biological covered under Part B of Medicare may be made only on an assignment-related basis. Therefore, no charge or bill may be rendered to anyone for these drugs and biologicals for any amount except the Medicare Part B deductible and coinsurance amounts.

(App. 118-119). The regulation clearly affects the calculation of the amount of the payment and does not restrict the person who may make a claim.

Medicare regulations establish the ability of a beneficiary to file his own claim. Specifically, 42 C.F.R. § 424.5(a)(5) sets forth who may make a claim for payment. It provides that "the provider, supplier, *or beneficiary*, as appropriate, must file a claim that includes or makes reference to a request for payment." 42 C.F.R. § 424.5(a)(5). (Emphasis added). As an additional example, 42 C.F.R. § 405.906 identifies the "parties

to the initial determination" as including "a beneficiary who filed a claim for payment under Medicare Part A or Part B ..." 42 C.F.R. § 405.906(a)(1).

Therefore, a Medicare beneficiary has the right to file his own claim for reimbursement under Part B. By filing his own claim, that beneficiary may then seek review of any adverse decision through the administrative process, and if not satisfied by the administrative process, he may then seek judicial review. As indicated, the judicial review is not sought, however, by pursuit of a state law negligence claim, but rather pursuant to the judicial review allowed under 42 U.S.C. § 405(g). In sum, a Medicare beneficiary is not deprived of his due process rights, and hence, there is no basis for the issuance of a writ of certiorari on that basis.

CONCLUSION

For the foregoing reasons, the Respondents submit that the Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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